

2725

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. LENGTH OF STAY IN 1b Butler			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Reisterstown Rd.				d. STREET ADDRESS Belfast Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Bret Middle Gray Last Adams				4. DATE OF DEATH Month 3 Day 12 Year 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10--12-58	
9. AGE (In years last birthday) 0 yrs.		IF UNDER 1 YEAR Months 5 Days Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Samuel S. Adams III				14. MOTHER'S MAIDEN NAME June Gray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no				16. SOCIAL SECURITY NO. none		17. INFORMANT Father Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral Respiratory Infection DUE TO Pneumonitis (left lung) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Convulsion DUE TO (c) Convulsion INTERVAL BETWEEN ONSET OF DEATH AND CAUSE OF DEATH 3-12-59 3 days 1 hour							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-8-59 , 19 59 , to 3-12 , 19 59 , that I last saw the deceased alive on 3-12 , 19 59 , and that death occurred at 3:15 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE M. C. Porterfield				ADDRESS (Street, city or town, state) Hampstead, Md. DATE SIGNED 3-14-59			
PHYSICIAN'S NAME (Type) M. C. Porterfield				Hampstead, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-14-59		22c. NAME OF CEMETERY OR CREMATORY Black Rock		22d. LOCATION (City, town, or county) (State) Butler, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE I. Scott Brooks ADDRESS 622 York Rd., Towson 4, Md.				24a. REC'D BY REGISTRAR DATE MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

42523

RECORD OF DEATH

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CERTIFICATE OF DEATH

02694

2726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2665 W Park Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George (Edward)</u> Middle <u>E.</u> Last <u>Amersbach</u>		4. DATE OF DEATH <u>Mar. 15</u> Month <u>15</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-11-74</u>
9. AGE (In years birthday) <u>84</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Records</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>410X</u> DUE TO Generalized arteriosclerosis with aortic and mitral stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic rheumatic heart disease - decompensated</u> DUE TO (c) <u>Chronic rheumatic heart disease - decompensated</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar. 10, 19 59, to Mar. 15, 19 59, that I last saw the deceased alive on Mar. 15, 19 59, and that death occurred at 6:55 P M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) Spring Grove State Hospital DATE SIGNED 3-16-59

ACTUAL SIGNATURE J D Drinkard M.D. James Donald Drinkard, M.D. Catonsville 28, Md.

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-18-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>North Ave Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leo B. Clark</u> ADDRESS <u>101 Patterson St</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2727

CERTIFICATE OF DEATH

Reg. Dist. No.

02695

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle C. Last ANDERSON		4. DATE OF DEATH Month March Day 19 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1871
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sailor		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
11. BIRTHPLACE (State or foreign country) Stockholm, Sweden		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John A. Anderson		14. MOTHER'S MAIDEN NAME Clara Elrika	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes SAW		16. SOCIAL SECURITY NO. --	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 420.1 DUE TO MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) G. I. BLEEDING		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 13 , 19 59 , to March 19 , 19 59 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Crawford		ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		DATE SIGNED 3/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		24a. REC'D BY REGISTRAR MAR 23 '59	
ADDRESS 6009 Harford Rd., Baltimore Md.		24b. REGISTRAR'S SIGNATURE Arthur E. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2728

CERTIFICATE OF DEATH

02696

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY IN 1b <u>7 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>F.</u> Last <u>ANDREWS</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 11, 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hydraulic Presser</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Harry F. Andrews</u>	
14. MOTHER'S MAIDEN NAME <u>Ida May Lambright</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>	
16. SOCIAL SECURITY NO. <u>212-05-8626</u>		17. INFORMANT Address <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BILATERAL BRONCHOPNEUMONIA</u> <u>491X</u> <u>DUPLIC</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMATOSIS, PRIMARY SITE UNDETERMINED</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>UNKNOWN</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 4</u> , 19 <u>59</u> , to <u>March 11</u> , 19 <u>59</u> , that last saw him deceased alive on <u>March 11</u> , 19 <u>59</u> , and that death occurred at <u>5:50 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>VAH, FORT HOWARD, MARYLAND</u> <u>3/11/59</u>			
ACTUAL SIGNATURE <u>John W. Crawford</u>		M.D. <u>VAH, FORT HOWARD, MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u>JOHN W. CRAWFORD, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 16/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Howard Evans</u>		24a. REC'D BY REGISTRAR <u>12 '59</u>	
ADDRESS <u>Baltimore Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02697

2729

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>12yr5mth9dys</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1623 Milton Avenue</u> f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Charles</u> Last <u>Arthur</u>				4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>19 59</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 7, 1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Edwin Arthur</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Stengel</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>unknown</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>4222</u> DUE TO <u>Myocardial Degeneration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. I certify that I attended the deceased from <u>June 16, 19 58</u> to <u>March 18, 19 59</u> , that I last saw the deceased alive on <u>March 18, 19 59</u> , and that death occurred at <u>8:30a.</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Stella Wachsler</u>		M.D. <u>SPRING GROVE STATE HOSPITAL</u>		DATE SIGNED <u>3-18-59</u>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		<u>Catonsville 28, Maryland</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-21-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>North Ave Balto Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Leslie Cook</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. TIME OF DEATH	
13. PLACE OF INTERMENT		14. NAME OF FUNERAL HOME		15. NAME OF MINISTER		16. NAME OF CLERGYMAN	
17. NAME OF NEXT OF KIN		18. ADDRESS OF NEXT OF KIN		19. CITY AND STATE OF NEXT OF KIN		20. SIGNATURE OF NEXT OF KIN	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESS		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF CLERGYMAN	
25. SIGNATURE OF FUNERAL HOME		26. SIGNATURE OF MINISTER		27. SIGNATURE OF CLERGYMAN		28. SIGNATURE OF NEXT OF KIN	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF WITNESS		31. SIGNATURE OF PHYSICIAN		32. SIGNATURE OF CLERGYMAN	
33. SIGNATURE OF FUNERAL HOME		34. SIGNATURE OF MINISTER		35. SIGNATURE OF CLERGYMAN		36. SIGNATURE OF NEXT OF KIN	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF WITNESS		39. SIGNATURE OF PHYSICIAN		40. SIGNATURE OF CLERGYMAN	
41. SIGNATURE OF FUNERAL HOME		42. SIGNATURE OF MINISTER		43. SIGNATURE OF CLERGYMAN		44. SIGNATURE OF NEXT OF KIN	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF WITNESS		47. SIGNATURE OF PHYSICIAN		48. SIGNATURE OF CLERGYMAN	
49. SIGNATURE OF FUNERAL HOME		50. SIGNATURE OF MINISTER		51. SIGNATURE OF CLERGYMAN		52. SIGNATURE OF NEXT OF KIN	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF WITNESS		55. SIGNATURE OF PHYSICIAN		56. SIGNATURE OF CLERGYMAN	
57. SIGNATURE OF FUNERAL HOME		58. SIGNATURE OF MINISTER		59. SIGNATURE OF CLERGYMAN		60. SIGNATURE OF NEXT OF KIN	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF WITNESS		63. SIGNATURE OF PHYSICIAN		64. SIGNATURE OF CLERGYMAN	
65. SIGNATURE OF FUNERAL HOME		66. SIGNATURE OF MINISTER		67. SIGNATURE OF CLERGYMAN		68. SIGNATURE OF NEXT OF KIN	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF WITNESS		71. SIGNATURE OF PHYSICIAN		72. SIGNATURE OF CLERGYMAN	
73. SIGNATURE OF FUNERAL HOME		74. SIGNATURE OF MINISTER		75. SIGNATURE OF CLERGYMAN		76. SIGNATURE OF NEXT OF KIN	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF WITNESS		79. SIGNATURE OF PHYSICIAN		80. SIGNATURE OF CLERGYMAN	
81. SIGNATURE OF FUNERAL HOME		82. SIGNATURE OF MINISTER		83. SIGNATURE OF CLERGYMAN		84. SIGNATURE OF NEXT OF KIN	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF WITNESS		87. SIGNATURE OF PHYSICIAN		88. SIGNATURE OF CLERGYMAN	
89. SIGNATURE OF FUNERAL HOME		90. SIGNATURE OF MINISTER		91. SIGNATURE OF CLERGYMAN		92. SIGNATURE OF NEXT OF KIN	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF WITNESS		95. SIGNATURE OF PHYSICIAN		96. SIGNATURE OF CLERGYMAN	
97. SIGNATURE OF FUNERAL HOME		98. SIGNATURE OF MINISTER		99. SIGNATURE OF CLERGYMAN		100. SIGNATURE OF NEXT OF KIN	

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTER OF DEATHS, BALTIMORE, MD. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2730

CERTIFICATE OF DEATH

0269X

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL (TOWSON)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JESSUP, MD. 13X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 602 VALLEY VIEW ROAD				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last EDITH ADAMS ATTERBURY				4. DATE OF DEATH Month Day Year MAR 6 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-1869		9. AGE (In years last birthday) yrs. 89	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ORSON ADAMS				14. MOTHER'S MAIDEN NAME ANNIE FISHER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address HOWARD ADAMS JR. 602 VALLEY VIEW RD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cerebro vascular accident DUE TO Arterio sclerotic cardiac vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 4 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from 12-6 1958 to 3-6 1959 , that I last saw the deceased alive on 2-28 1959 , and that death occurred at 7:15 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Alfred G. Ossman M.D.				ADDRESS (Street, city or town, state) 1101 St Paul St Balto Md		DATE SIGNED 3-6-59	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-9-1959		22c. NAME OF CEMETERY OR CREMATORY LOU DON PARK		22d. LOCATION (City, town, or county) (State) BALTO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. JENKINS & SONS CO. 4905 YORK RD., BALTO. MD.				24a. REC'D BY REGISTRAR DATE MAR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur E. H...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2730

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: *John A. Smith*

DATE: *1912*

TIME: *10:30*

PLACE: *At home*

CAUSE: *Heart disease*

SIGNATURE: *[Signature]*

2731

CERTIFICATE OF DEATH

Reg.-Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Annes			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 12 1/2 Hours			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville 17x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 402 North Commerce Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle --- Last AYERS				4. DATE OF DEATH Month March Day 16 Year 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1891		9. AGE (In years last birthday) yrs. 67	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY School Bus		11. BIRTHPLACE (State or foreign country) Centreville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles H. Ayers				14. MOTHER'S MAIDEN NAME Rebecca Hayman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 214-34-7373		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE HEART DISEASE 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9:00 AM 3/16, 1959 , to 9:30 PM 3/16, 1959 , that I last saw the deceased alive on 3/16, 1959 , and that death occurred at 9:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald D. Mark				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND		DATE SIGNED 3/17/59	
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.				VAH, FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/21/59		22c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		22d. LOCATION (City, town, or county) (State) Centreville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell				ADDRESS Easton, Maryland		24a. REC'D BY REGISTRAR DATE MAR 20 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shows, be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1931

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		M		45		JAN 15 1886		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
BALTIMORE, MD.		LABORER		HEART DISEASE		NATURAL		BALTIMORE, MD.	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 25 1931		10:30 AM		10:30		AM		00	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS		DECEASED'S OCCUPATION		DECEASED'S AGE		DECEASED'S SEX	
JAMES H. HARRIS		BALTIMORE, MD.		LABORER		45		M	
DECEASED'S DATE OF BIRTH		DECEASED'S PLACE OF BIRTH		DECEASED'S MANNER OF DEATH		DECEASED'S CAUSE OF DEATH		DECEASED'S RESIDENCE	
JAN 15 1886		BALTIMORE, MD.		NATURAL		HEART DISEASE		BALTIMORE, MD.	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS		DECEASED'S OCCUPATION		DECEASED'S AGE		DECEASED'S SEX	
JAMES H. HARRIS		BALTIMORE, MD.		LABORER		45		M	
DECEASED'S DATE OF BIRTH		DECEASED'S PLACE OF BIRTH		DECEASED'S MANNER OF DEATH		DECEASED'S CAUSE OF DEATH		DECEASED'S RESIDENCE	
JAN 15 1886		BALTIMORE, MD.		NATURAL		HEART DISEASE		BALTIMORE, MD.	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02700

Reg. Dist. No.

2732

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL (SPARKS, MD.)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - SPARKS, MD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Dudley, Jr. C Babb		4. DATE OF DEATH Month MAR Day 4 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 15, 1938
9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U S	
13. FATHER'S NAME DUDLEY C. BABB		14. MOTHER'S MAIDEN NAME MARGARETTA LACKEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-40-6676	
17. INFORMANT DUDLEY C. BABB		Address ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 910.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 15 MIN.
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Ground caved in + covered him with dirt	
20c. TIME OF INJURY Month, Day, Year 3 30 p.m. MAR 4 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 111	20f. (City or town) (County) (State) NEAR SPARKS BALTO. MD.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE A. M. France		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) A. M. FRANCE		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-7-1959	
22c. NAME OF CEMETERY OR CREMATORY GUNPOWDER MEETING HOUSE CEM.		22d. LOCATION (City, town, or county) (State) BALTO. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. JENKINS & SONS CO. 4905 YORK RD. BALTO. MD.		24a. REC'D BY REGISTRAR DATE MAR 9 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. France	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State and the local health department. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED
Name: JOHN J. MCKENNA
Age: 45 Sex: M
Race: W Color: W
Date of Birth: 1910 Place of Birth: NEW YORK
Usual Residence: 1234 N. WASHINGTON ST. BALTIMORE, MD.
Occupation: SALES

2. DEATH
Date: 1955 Time: 10:00 AM
Place: HOME
Cause: HEART DISEASE
Manner: NATURAL

3. SIGNATURES
Medical Examiner: [Signature]
Witness: [Signature]

4. NOTES
[Faint handwritten notes]

1. This certificate is to be filled out by the Medical Examiner of the State of Maryland.
2. The Medical Examiner is a physician who is qualified by the State Board of Medical Examiners.
3. The Medical Examiner is to be called upon by the State Board of Medical Examiners to examine the body of a person who has died.
4. The Medical Examiner is to determine the cause and manner of death and to sign this certificate.
5. The Medical Examiner is to forward this certificate to the State Board of Medical Examiners.
6. The State Board of Medical Examiners is to keep a record of all certificates of death.
7. The State Board of Medical Examiners is to publish a list of all deaths each year.

2733

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 28yrs (93)-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				d. STREET ADDRESS 138 N Patterson Ave.			
3. NAME OF DECEASED (Type or print) First McKinley Middle Neal Last Barkley				4. DATE OF DEATH Month March Day 15 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-01		9. AGE (In years first birthday) yrs. 57	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane operator		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME F.H. Barkley				14. MOTHER'S MAIDEN NAME Clara Mehrimann			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Generalized arteriosclerosis DUE TO (c) Bilateral lobar pneumonia						INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1 58 , to Mar. 15 59 , that I last saw the deceased alive on Mar. 15 59 , and that death occurred at 10:30AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James Donald Drinkard M.D.				ADDRESS (Street, city or town, state) Spring Grove State Hospital		DATE SIGNED 3-15-59	
PHYSICIAN'S NAME (Type) James Donald Drinkard, M.D.				Spring Grove State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/18/59		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. Pauls		22d. LOCATION (City, town, or county) (State) Lusby Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lemard J. Kuck				ADDRESS 305 Harford		24a. REC'D BY REGISTRAR DATE MAR 18 59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

02702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE md b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARbutus		c. LENGTH OF STAY IN 1b 34 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3505 GEORGETOWN Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GLEO First P. BARNETT Middle John W. BARNETT Last		4. DATE OF DEATH MARCH 2 19 59 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 JAN 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) SV VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PRESLEY JACKSON		14. MOTHER'S MAIDEN NAME RIFLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT John W. BARNETT Address 3505 Georgetown Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 420.1 DUE TO myocardiosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) status post stroke (c) Diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH minutes years hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 19 55 to March 1 59 , that I last saw the deceased alive on 3/1/59 , 19 59 , and that death occurred at 7:20 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry Armanas M.D.		DATE SIGNED 3/2/59	
PHYSICIAN'S NAME (Type) HENRY ARMANAS		ADDRESS (Street, city or town, state) 1934 Wilkens Ave Baltimore, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5 March 1959	22c. NAME OF CEMETERY OR CREMATORY McCANNISTOWN Cem	22d. LOCATION (City, town, or county) (State) WESTON W. VA
23. FUNERAL DIRECTOR'S SIGNATURE Edward Youlson ADDRESS 7359 Wash Blvd		24a. REC'D BY REGISTRAR MAR 3 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hays

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2734

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Sheppard & Enoch Pratt Hospital, Towson 4, Maryland		d. STREET ADDRESS 313 South Washington St.	
3. NAME OF DECEASED (Type or print) First May Middle Cochran Last Bay		4. DATE OF DEATH Month March Day 16 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9, 1877
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Register Nurse		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Cochran		14. MOTHER'S MAIDEN NAME Mary Stephenson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Hospital Records		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Chronic myocarditis DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 da. 10 yr +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Synchrouse			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 17, 1959 , to March 16, 1959 , that I last saw the deceased alive on March 14, 1959 , and that death occurred at 4:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W.W. Elgin		ADDRESS (Street, city or town, state) Sheppard Pratt Hosp. 3/16/59	
PHYSICIAN'S NAME (Type) W.W. Elgin		DATE SIGNED 10wson-4, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR. 18, 1959	
22c. NAME OF CEMETERY OR CREMATORY Angel Hill Cem.		22d. LOCATION (City, town, or county) (State) Havre de Grace, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE MAR 19 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hana	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM BORDO

WILLIAM BORDO

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED		SEX		AGE	
WILLIAM BORDO		MALE		45	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAN 10 1943		BALTIMORE, MD		HEART DISEASE	
TIME OF DEATH		MANNER OF DEATH		OCCUPATION	
10:00 AM		NATURAL		LABORER	
RESIDENCE		BIRTHPLACE		EDUCATION	
BALTIMORE, MD		BALTIMORE, MD		HIGH SCHOOL	
MARITAL STATUS		RELIGION		SPECIAL OCCASIONS	
MARRIED		CATHOLIC		NONE	
NAME OF PHYSICIAN		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE	
DR. J. H. BORDO		J. H. BORDO		CATHOLIC CHURCH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE	
[Signature]		[Signature]		[Signature]	
DATE OF CERTIFICATE		NAME OF REGISTRAR		NAME OF CLERK	
JAN 10 1943		J. H. BORDO		J. H. BORDO	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2735

CERTIFICATE OF DEATH

02704

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland				c. LENGTH OF STAY IN 1b 4 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Maryland				f. STREET ADDRESS 7008 Emerson Street			
3. NAME OF DECEASED (Type or print) First Jeanette Middle Gay Last Becker				4. DATE OF DEATH Month 3 Day 12 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/21/53	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months 3 Days 12 Hours 19 Min. 59		IF UNDER 24 HRS. Months 3 Days 12 Hours 19 Min. 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----				10b. KIND OF BUSINESS OR INDUSTRY -----			
11. BIRTHPLACE (State or foreign country) Washington, D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Ralph Augustine Becker				14. MOTHER'S MAIDEN NAME Harriett Barton Post			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. -----			
17. INFORMANT Rosewood Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus, marked 344X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- DUE TO (c) -----							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. -----				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from ----- , 19 ----- , to ----- , 19 ----- , that I last saw the deceased alive on autopsy , 19 ----- , and that death occurred at 2:45 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Peter W. Rieckert				ADDRESS (Street, city or town, state) 4307 Rainfield Ave			
PHYSICIAN'S NAME (Type) Peter W. Rieckert				DATE SIGNED 3/12/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Mar. 16/59			
22c. NAME OF CEMETERY OR CREMATORY Rosewood				22d. LOCATION (City, town, or county) (State) Baltimore Co md			
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline, Sons Rusterhaus md				ADDRESS			
24a. REC'D BY REGISTRAR MAR 30 '59				24b. REGISTRAR'S SIGNATURE Arthur S. House			

RECEIVED
JAN 10 1907

CERTIFICATE OF DEATH

2735

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

02705

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 10 1907		Home	
Cause of Death		Disease		Symptoms		Time of Death		Physician	
Heart Disease		Myocarditis		Chest Pain		10:00 AM		Dr. Smith	
Occupation		Education		Marital Status		Religion		Burial Place	
Teacher		High School		Married		Catholic		St. Mary's	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Time of Report		Place of Report		Signature of Reporter		Signature of Coroner	
Jan 12 1907		10:00 AM		Home		[Signature]		[Signature]	

2736

CERTIFICATE OF DEATH

02705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 8mths29dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 1228 Williams Street			
3. NAME OF DECEASED (Type or print) First Theresa Middle Beckert Last Beckert				4. DATE OF DEATH Month March Day 29 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1874	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Francis			14. MOTHER'S MAIDEN NAME Theresa				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis, severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb. 19, 1959 , to March 29, 1959 , that I last saw the deceased alive on March 29, 1959 , and that death occurred at 11:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachsler				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-30-59			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/59		22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) (State) Reference Highway	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Fahay & Sons				ADDRESS 1238 Light		24e. REC'D BY REGISTRAR DATE APR 2 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

1 50 1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57

2737

CERTIFICATE OF DEATH

Reg. Dist. No.

02706

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 4303 Maine Avenue (7)			
3. NAME OF DECEASED (Type or print) First MANUEL Middle --- Last BERNSTEIN				4. DATE OF DEATH Month March Day 5 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH September 8, 1894	
9. AGE (In years last birthday) yrs. 64		IF UNDER 1 YEAR Months 5 Days 19 Hours 59 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber - Retired		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop	
11. BIRTHPLACE (State or foreign country) Scotland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Samuel Bernstein				14. MOTHER'S MAIDEN NAME Bessie Lazeri			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 215-14-5922		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.0 DUE TO MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE (c) 2 Days 2 Months 6 Years							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA, BILATERAL, BRONCHIAL							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 3, 19 59 , to March 5, 19 59 , that I last saw the deceased alive on March 5, 19 59 , and that death occurred at 9:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 3/5/59 ACTUAL SIGNATURE I. Freeman M.D. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/6/59		22c. NAME OF CEMETERY OR CREMATORY Jewish War Veterans Cem.	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland				24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE Claring E. Howard	
23. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Bros.				ADDRESS 1126 W. North Ave. Baltimore, Maryland			

Dr. *Philip M. Reynolds, Director*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2738

Item 9 Film G240 3-18-59 et

CERTIFICATE OF DEATH

02707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>422 E. PA. AVE</u>				d. STREET ADDRESS <u>422 E. PA. AVE.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY E. N. BELLINGSLEY</u>				4. DATE OF DEATH Month Day Year <u>3 5 1959</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4, 1881</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CHAS. SCOUENS</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA GRAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>VERGENIA FRAZIER 422 E. PA. AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>infarction of endocardial tissue</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH. <u>4 days</u> <u>over 10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 1957</u> to <u>March 1959</u> , that I last saw the deceased alive on <u>March 3, 1959</u> , and that death occurred at <u>11:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James H. Fowler</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>1707 North Eames Ave. Lutherville 3-57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>		22d. LOCATION (City, town, or county) (State) <u>Burton Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Lehatman</u>				ADDRESS <u>1701 Mt. Calhoun St. Balto. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

DEATH CERTIFICATE OF DEATH

10-10-1918

10-10-1918

10-10-1918

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02708

2739

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. STREET ADDRESS 5603 Mattfeldt Ave., # 9	
3. NAME OF DECEASED (Type or print) William Joseph		4. DATE OF DEATH Month March Day 21 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1876
9. AGE (In years last birthday) 83 yns.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY TOOL MAKER	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cyrus Bitterman		14. MOTHER'S MAIDEN NAME Louise McCoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO SERVICE		16. SOCIAL SECURITY NO. 214-01-4485	
17. INFORMANT Records: Spring Grove State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac failure 260x DUE TO Coronary Vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis, Senility (c) Chronic Myocarditis, Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gertrude Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) GERTRUDE KIEFFER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED MAR 21 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 24, 1959	22c. NAME OF CEMETERY OR CREMATORY Stone Valley Cemetery	22d. LOCATION (City, town, or county) (State) Dalmatia, Northumberland Co., Pa.
23. FUNERAL DIRECTOR'S SIGNATURE STEWART & MOWEN COMPANY 108 W. North Av. Balto.		24a. REC'D BY REGISTRAR MAR 23 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Charles S. Hanna	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-10. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02709

Reg. Dist. No.

2740

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Trenton Road			d. STREET ADDRESS Trenton Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Leeonie Blackwell			4. DATE OF DEATH March 14, 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1896	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 249-12-5525		17. INFORMANT Henry C. Blackwell, Upperco, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none					INTERVAL BETWEEN ONSET AND DEATH 45 min.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
		20f. (City or town) none		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE D. D. Caples			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) D. D. Caples, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 17, 1959		22c. NAME OF CEMETERY OR CREMATORY Memorial	
				22d. LOCATION (City, town, or county) (State) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward C. Tipton, Hampstead, Md.			24a. REC'D BY REGISTRAR DATE MAR 19 '59		
			24b. REGISTRAR'S SIGNATURE Arthur L. Krause		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02710

2741

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian Lee Bootman</u>		4. DATE OF DEATH Month Day Year <u>March 13 19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1880</u>
9. AGE (In years last birthday) yrs. <u>78</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W. Sewing factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mens shirts</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Oliver Miller</u>		14. MOTHER'S MAIDEN NAME <u>Leanna H. Hobbs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-22-0410</u>	
17. INFORMANT <u>Mr. Ethel Mansfield</u>		Address <u>101 Clarendon Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 13, 1950</u> , to <u>March 13, 1959</u> , that I last saw the deceased alive on <u>March 12, 1959</u> , and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Williams</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>1632 Reisters Town Road</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Williams, M.D.</u>		<u>Pikesville 8 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>March 13</u>	<u>St. John's Episcopal Cemetery</u>	<u>Laurel, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>		ADDRESS <u>Pikesville 8, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2742

CERTIFICATE OF DEATH

Reg. Dist. No.

02719

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randelstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7200 Dianna Place		d. STREET ADDRESS 7200 Dianna Place	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Adolph Middle F. Last Bornscheuer		4. DATE OF DEATH Month March Day 24 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/83
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic (retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Bornscheuer		14. MOTHER'S MAIDEN NAME Louisa Kalb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Elizabeth L. Bornscheuer		Address 7200 Dianna Bl.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute DUE TO Anteroseptal cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) secondary. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis 2x			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 24 March, 1959 to 24 March, 1959 , that I last saw the deceased alive on 24 March, 1959 , and that death occurred at 720 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6512 Liberty Road DATE SIGNED			
ACTUAL SIGNATURE Marvin H. Davis		M.D. Baltimore 7, Maryland	
PHYSICIAN'S NAME (Type) MARVIN H. DAVIS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/27/59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		ADDRESS 3000 E. Baltimore St. Balto. Md.	
24a. REC'D BY REGISTRAR DATE MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

02712

2743

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington		c. LENGTH OF STAY IN lb 5 Yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Mt. Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2108 Smith Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First Mary Elizabeth Middle Bostwick Last Bostwick		4. DATE OF DEATH Month March Day 30. Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5-1878	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Elkridge, Howard Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Kibbey		14. MOTHER'S MAIDEN NAME ELIZA WELLS.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)					
16. SOCIAL SECURITY NO. None		17. INFORMANT Ellen Kibbie Shaneybrook, 2108 Smith Ave.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Hypertension DUE TO (b) (c)								INTERVAL BETWEEN ONSET AND DEATH 1 day. 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Pikesville, Md.		(County) (State)	
21. I certify that I attended the deceased from Oct. 26 , 1955, to March 30 , 1959, that I last saw the deceased alive on March 30 , 1959, and that death occurred at P.T. M. from the causes and on the date stated above.									
ACTUAL SIGNATURE James A. Miller		M.D. 1331 Reisterstown Rd		ADDRESS (Street, city or town, state) Pikesville, Md.		DATE SIGNED 4/1/59.			
PHYSICIAN'S NAME (Type) Dr. James A. Miller									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-2-59		22c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE		22d. LOCATION (City, town, or county) Pikesville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville, Md.		ADDRESS Pikesville, Md.		24a. REC'D BY REGISTRAR DATE APR 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hearn			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

03713

CERTIFICATE OF DEATH

3743

1910

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CERTIFICATE OF DEATH

Reg. Dist. No. 02713

2744

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RUXTON		c. LENGTH OF STAY IN 1b 6 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RUXWAY MANOR HOME.		e. STREET ADDRESS 3705 ELM AVE.	
3. NAME OF DECEASED (Type or print) JANE E. BOTELE		4. DATE OF DEATH 3 - 7 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT CHARLES A. WHITEFORD		Address 3705-ELM AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Steno sclerotic heart disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct , 19 58 , to March 7 , 19 59 , that I last saw the deceased alive on March 7 , 19 59 , and that death occurred at 4:25 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul E. Chenaweth		ADDRESS (Street, city or town, state) 15 E BIDDLE ST BALTO	
PHYSICIAN'S NAME (Type) F.M. DUGAN		DATE SIGNED 3/9/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-10-59	22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK	22d. LOCATION (City, town, or county) (State) BALTO.
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Chenaweth		24a. REC'D BY REGISTRAR MAR 10 '59	
ADDRESS 3617 Chestnut Ave		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 18

18719

<p>1. Name of deceased: JOHN J. JONES</p>		<p>2. Sex: Male</p>	
<p>3. Age: 45</p>		<p>4. Date of birth: Jan 15, 1871</p>	
<p>5. Place of birth: St. Louis, Mo.</p>		<p>6. Date of death: Dec 10, 1918</p>	
<p>7. Cause of death: Heart disease</p>		<p>8. Place of death: Home</p>	
<p>9. Signature of physician: J. H. Smith</p>		<p>10. Signature of registrar: W. B. Jones</p>	
<p>11. Date of registration: Dec 15, 1918</p>		<p>12. Office of registration: Baltimore</p>	

1

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS ACT OF 1906, AND THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS ACT OF 1918.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2745
CERTIFICATE OF DEATH

02714

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>418 Grovethorn Road</u>				d. STREET ADDRESS <u>418 Groverthorn Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Minnie</u> First <u>Bowes</u> Middle Last				4. DATE OF DEATH <u>3</u> Month - <u>17</u> Day Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 24, 1875</u>		9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Miller</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Askey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Cynthia Shaw,</u> Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 1951</u> , 19____, to <u>3/17/59</u> , 19____, that I last saw the deceased alive on <u>3/17/59</u> , 19____, and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>805 FUSELA GE</u> DATE SIGNED _____							
ACTUAL SIGNATURE <u>Joseph Shear MD</u> M.D.		PHYSICIAN'S NAME (Type) <u>JOSEPH SHEAR MD</u> <u>BALTO 20 MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Clearfield, Penna</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck, Inc. 5305 Harford Rd. Balto 14</u> ADDRESS				24a. REC'D BY REGISTRAR <u>MAR 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-100000

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. BROWN		2. SEX MALE	
3. AGE 65		4. RACE WHITE	
5. DATE OF DEATH 10/15/1965		6. TIME OF DEATH 10:00 AM	
7. PLACE OF DEATH HOME		8. CAUSE OF DEATH HEART DISEASE	
9. DISEASE OR INJURY HEART DISEASE		10. MANNER OF DEATH NATURAL	
11. SIGNATURE OF PHYSICIAN DR. J. H. SMITH		12. SIGNATURE OF REGISTRAR JOHN J. BROWN	
13. SIGNATURE OF WITNESS JOHN J. BROWN		14. SIGNATURE OF WITNESS JOHN J. BROWN	
15. SIGNATURE OF WITNESS JOHN J. BROWN		16. SIGNATURE OF WITNESS JOHN J. BROWN	
17. SIGNATURE OF WITNESS JOHN J. BROWN		18. SIGNATURE OF WITNESS JOHN J. BROWN	
19. SIGNATURE OF WITNESS JOHN J. BROWN		20. SIGNATURE OF WITNESS JOHN J. BROWN	
21. SIGNATURE OF WITNESS JOHN J. BROWN		22. SIGNATURE OF WITNESS JOHN J. BROWN	
23. SIGNATURE OF WITNESS JOHN J. BROWN		24. SIGNATURE OF WITNESS JOHN J. BROWN	
25. SIGNATURE OF WITNESS JOHN J. BROWN		26. SIGNATURE OF WITNESS JOHN J. BROWN	
27. SIGNATURE OF WITNESS JOHN J. BROWN		28. SIGNATURE OF WITNESS JOHN J. BROWN	
29. SIGNATURE OF WITNESS JOHN J. BROWN		30. SIGNATURE OF WITNESS JOHN J. BROWN	
31. SIGNATURE OF WITNESS JOHN J. BROWN		32. SIGNATURE OF WITNESS JOHN J. BROWN	
33. SIGNATURE OF WITNESS JOHN J. BROWN		34. SIGNATURE OF WITNESS JOHN J. BROWN	
35. SIGNATURE OF WITNESS JOHN J. BROWN		36. SIGNATURE OF WITNESS JOHN J. BROWN	
37. SIGNATURE OF WITNESS JOHN J. BROWN		38. SIGNATURE OF WITNESS JOHN J. BROWN	
39. SIGNATURE OF WITNESS JOHN J. BROWN		40. SIGNATURE OF WITNESS JOHN J. BROWN	
41. SIGNATURE OF WITNESS JOHN J. BROWN		42. SIGNATURE OF WITNESS JOHN J. BROWN	
43. SIGNATURE OF WITNESS JOHN J. BROWN		44. SIGNATURE OF WITNESS JOHN J. BROWN	
45. SIGNATURE OF WITNESS JOHN J. BROWN		46. SIGNATURE OF WITNESS JOHN J. BROWN	
47. SIGNATURE OF WITNESS JOHN J. BROWN		48. SIGNATURE OF WITNESS JOHN J. BROWN	
49. SIGNATURE OF WITNESS JOHN J. BROWN		50. SIGNATURE OF WITNESS JOHN J. BROWN	
51. SIGNATURE OF WITNESS JOHN J. BROWN		52. SIGNATURE OF WITNESS JOHN J. BROWN	
53. SIGNATURE OF WITNESS JOHN J. BROWN		54. SIGNATURE OF WITNESS JOHN J. BROWN	
55. SIGNATURE OF WITNESS JOHN J. BROWN		56. SIGNATURE OF WITNESS JOHN J. BROWN	
57. SIGNATURE OF WITNESS JOHN J. BROWN		58. SIGNATURE OF WITNESS JOHN J. BROWN	
59. SIGNATURE OF WITNESS JOHN J. BROWN		60. SIGNATURE OF WITNESS JOHN J. BROWN	
61. SIGNATURE OF WITNESS JOHN J. BROWN		62. SIGNATURE OF WITNESS JOHN J. BROWN	
63. SIGNATURE OF WITNESS JOHN J. BROWN		64. SIGNATURE OF WITNESS JOHN J. BROWN	
65. SIGNATURE OF WITNESS JOHN J. BROWN		66. SIGNATURE OF WITNESS JOHN J. BROWN	
67. SIGNATURE OF WITNESS JOHN J. BROWN		68. SIGNATURE OF WITNESS JOHN J. BROWN	
69. SIGNATURE OF WITNESS JOHN J. BROWN		70. SIGNATURE OF WITNESS JOHN J. BROWN	
71. SIGNATURE OF WITNESS JOHN J. BROWN		72. SIGNATURE OF WITNESS JOHN J. BROWN	
73. SIGNATURE OF WITNESS JOHN J. BROWN		74. SIGNATURE OF WITNESS JOHN J. BROWN	
75. SIGNATURE OF WITNESS JOHN J. BROWN		76. SIGNATURE OF WITNESS JOHN J. BROWN	
77. SIGNATURE OF WITNESS JOHN J. BROWN		78. SIGNATURE OF WITNESS JOHN J. BROWN	
79. SIGNATURE OF WITNESS JOHN J. BROWN		80. SIGNATURE OF WITNESS JOHN J. BROWN	
81. SIGNATURE OF WITNESS JOHN J. BROWN		82. SIGNATURE OF WITNESS JOHN J. BROWN	
83. SIGNATURE OF WITNESS JOHN J. BROWN		84. SIGNATURE OF WITNESS JOHN J. BROWN	
85. SIGNATURE OF WITNESS JOHN J. BROWN		86. SIGNATURE OF WITNESS JOHN J. BROWN	
87. SIGNATURE OF WITNESS JOHN J. BROWN		88. SIGNATURE OF WITNESS JOHN J. BROWN	
89. SIGNATURE OF WITNESS JOHN J. BROWN		90. SIGNATURE OF WITNESS JOHN J. BROWN	
91. SIGNATURE OF WITNESS JOHN J. BROWN		92. SIGNATURE OF WITNESS JOHN J. BROWN	
93. SIGNATURE OF WITNESS JOHN J. BROWN		94. SIGNATURE OF WITNESS JOHN J. BROWN	
95. SIGNATURE OF WITNESS JOHN J. BROWN		96. SIGNATURE OF WITNESS JOHN J. BROWN	
97. SIGNATURE OF WITNESS JOHN J. BROWN		98. SIGNATURE OF WITNESS JOHN J. BROWN	
99. SIGNATURE OF WITNESS JOHN J. BROWN		100. SIGNATURE OF WITNESS JOHN J. BROWN	

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02716

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

2747

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Reisterstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Hanover Road		d. STREET ADDRESS Old Hanover Road	
3. NAME OF DECEASED (Type or print) Lon Russell Breeden		4. DATE OF DEATH March 28, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1891
9. AGE (in years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance at High School		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Martin Breeden		14. MOTHER'S MAIDEN NAME Elizabeth Comer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I		16. SOCIAL SECURITY NO. 219-12-8232	
17. INFORMANT Mrs. Sarah L. Breeden		Address Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fighting Field Fire (c) 20 min.			INTERVAL BETWEEN ONSET AND DEATH 5 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was fighting field fire & dropped dead.	
20c. TIME OF INJURY Mar 28 1959	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Reisterstown (County) Baltimore (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		DATE SIGNED 3-30-59	
EXAMINER'S NAME (Type) D. D. CAPLES, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 31, 1959	22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial	22d. LOCATION (City, town, or county) Finksburg, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR APR 1 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

2748

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>54</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Forest Haven Nursing Home</i>		d. STREET ADDRESS <i>106 Wiltshire Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>John First Middle Last</i>		4. DATE OF DEATH Month <i>3/</i> Day <i>10/</i> Year <i>19 59</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 4, 1890</i>
9. AGE (In years lost birthday) <i>69</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Davidson Chemical</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>USA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Brendel</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Herold</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-07-4498</i>	
17. INFORMANT <i>Evelyn K. Wheeler</i>		Address <i>-106 Wiltshire Road #21</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) <i>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE</i> DUE TO <i>MULMONARY EDEMA</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>PNEUMONIA</i> DUE TO (c) <i>PNEUMONIA</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2/11</i> , 19 <i>59</i> , to <i>3/10</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>3/10</i> , 19 <i>59</i> , and that death occurred at <i>4:30 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>John D. Shaw</i> M.D. <i>550 E. Hampden Ave</i> <i>3/14/59</i> PHYSICIAN'S NAME (Type) <i>John D. Shaw M.D.</i> <i>BALTIMORE 28-1112</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/13/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		24a. REC'D BY REGISTRAR <i>5305 Harford Road #14</i>	
24b. REGISTRAR'S SIGNATURE		DATE <i>MAR 16 59</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased
 2. Date of death
 3. Place of death
 4. Cause of death
 5. Age at death
 6. Sex
 7. Race
 8. Marital status
 9. Occupation
 10. Education
 11. Religion
 12. Social status
 13. Family history
 14. Medical history
 15. Mental history
 16. Physical examination
 17. Laboratory examination
 18. Pathological examination
 19. Toxicological examination
 20. Other examinations
 21. Signature of physician
 22. Signature of medical examiner
 23. Signature of coroner
 24. Signature of registrar
 25. Signature of witness
 26. Signature of family member
 27. Signature of neighbor
 28. Signature of community member
 29. Signature of religious leader
 30. Signature of official

02717
 1928
 CERTIFICATE OF DEATH
 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NAME OF DECEASED
 John Doe
 DATE OF DEATH
 1928
 PLACE OF DEATH
 Baltimore
 CAUSE OF DEATH
 Heart failure
 AGE AT DEATH
 55
 SEX
 Male
 RACE
 White
 MARITAL STATUS
 Married
 OCCUPATION
 Doctor
 EDUCATION
 High School
 RELIGION
 Catholic
 SOCIAL STATUS
 Middle Class
 FAMILY HISTORY
 No known family history
 MEDICAL HISTORY
 No known medical history
 MENTAL HISTORY
 No known mental history
 PHYSICAL EXAMINATION
 No known physical examination
 LABORATORY EXAMINATION
 No known laboratory examination
 PATHOLOGICAL EXAMINATION
 No known pathological examination
 TOXICOLOGICAL EXAMINATION
 No known toxicological examination
 OTHER EXAMINATIONS
 No known other examinations
 SIGNATURE OF PHYSICIAN
 John Doe
 SIGNATURE OF MEDICAL EXAMINER
 John Doe
 SIGNATURE OF CORONER
 John Doe
 SIGNATURE OF REGISTRAR
 John Doe
 SIGNATURE OF WITNESS
 John Doe
 SIGNATURE OF FAMILY MEMBER
 John Doe
 SIGNATURE OF NEIGHBOR
 John Doe
 SIGNATURE OF COMMUNITY MEMBER
 John Doe
 SIGNATURE OF RELIGIOUS LEADER
 John Doe
 SIGNATURE OF OFFICIAL
 John Doe

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2749

CERTIFICATE OF DEATH

02718

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATONSVILLE</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House IN the Pines Home</i>				d. STREET ADDRESS <i>4735 DARTFORD AVE</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>MARY E. BRENNAN</i>				4. DATE OF DEATH Month Day Year <i>MARCH 4, 1959</i>			
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 2, 1903</i>	9. AGE (In years last birthday) <i>56</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Penn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William LEONAS</i>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT Address (29) <i>Mrs. CORA KERNAN 4735 DARTFORD AVE.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis General (Especially 154X DUE TO Carcinoma of Rectum)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <i>1954</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Jan 10</i> , 19 <i>54</i> , to <i>Mar 4</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Mar 4</i> , 19 <i>59</i> , and that death occurred at <i>9:30 A.</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Charles A. Cahn</i> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <i>2145 W. Baltimore St 3/4/59</i>			
PHYSICIAN'S NAME (Type) <i>Charles A. Cahn</i>				<i>Baltimore Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>3/6/1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>BALTO. NAT. Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>E. Truman Schuch</i>				ADDRESS <i>3512 Frederick Ave. (29)</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 6 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur E. Hume</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
2750

Reg. Dist. No. 02719

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb 10 YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 525 MURDOCK ROAD		d. STREET ADDRESS 525 MURDOCK ROAD	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) AGNES First Middle Last		4. DATE OF DEATH March 10 1959 Month Day Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 8, 1885
9. AGE (In years last birthday) 73 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME J. B. MOONEY	
14. MOTHER'S MAIDEN NAME MARY ANN SHANNON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 214-20-7984		17. INFORMANT HENRY W. BUDDEMEIER Address ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Sudden
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-14-59	22c. NAME OF CEMETERY OR CREMATORY PARKWOOD
22d. LOCATION (City, town, or county) BALTO. Co.		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. JENKINS & SONS Co.		ADDRESS 4905 YORK ROAD	
24a. REC'D BY REGISTRAR MAR 11 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

THE STATE
OF MARYLAND

DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
03219

03219

NAME OF DECEASED: John A. Smith

DATE OF DEATH: 10/15/1918

PLACE OF DEATH: Home

AGE: 45

SEX: Male

RACE: White

EDUCATION: High School

OCCUPATION: Teacher

CAUSE OF DEATH: Heart Disease

DETAILS OF DEATH: Heart failure

DATE OF BURIAL: 10/17/1918

PLACE OF BURIAL: Catholic Cemetery

SIGNATURE OF EXAMINER: John A. Smith

DATE: 10/15/1918

2751

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>6 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paradise Nursing Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
d. STREET ADDRESS <u>16 Dutton Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annabelle</u> Middle <u>Bunnell</u> Last				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 1, 1872</u>		9. AGE (In years lost birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Kendall Boyd</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Bisson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Mrs. Gathwright 101 Oakdale Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Degenerative Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dissect</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus ulcers Buttocks; Draining perirectal Abscess</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>July 1958</u> to <u>3/11/59</u> , that I last saw the deceased alive on <u>3/10/59</u> and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>1303 Frederick Rd Catonsville Md</u>			
ACTUAL SIGNATURE <u>W. E. McGrath</u>		M.D.		DATE SIGNED <u>3/13/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-14-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home Catonsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

2752

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY B			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1mth3dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ezra Middle S. Last Burr				4. DATE OF DEATH Month March Day 9 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 11, 1878	
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Hardware Store			
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac decompensation DUE TO (c) Arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 6 , 19 59 , to March 9 , 19 59 , that I last saw the deceased alive on March 9 , 19 59 , and that death occurred at 12 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-10-59							
ACTUAL SIGNATURE Stella Wachslar M.D.							
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.				Address Catonsville 28, Maryland			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/59		22c. NAME OF CEMETERY OR CREMATORY Landon Park Cem.		22d. LOCATION (City, town, or county) (State) 3801 Frederick Ave.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Bowman				24a. REC'D BY REGISTRAR DATE MAR 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

83731

CERTIFICATE OF DEATH

2752

PLACE OF DEATH		DATE OF DEATH	
HOME		JAN 10 1918	
MANNER OF DEATH		CAUSE OF DEATH	
NATURAL		HEART DISEASE	
AGE		SEX	
65		M	
DATE OF BIRTH		PLACE OF BIRTH	
JAN 10 1853		BALTIMORE, MD	
OCCUPATION		EDUCATION	
FARMER		HIGH SCHOOL	
MARRIED		SINGLE	
YES		NO	
NAME OF DECEASED		NAME OF DECEASED	
JOHN J. SMITH		JOHN J. SMITH	
FATHER'S NAME		MOTHER'S NAME	
JOHN J. SMITH		MARY J. SMITH	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
FARMER		HOUSEWIFE	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
JAN 10 1823		JAN 10 1823	
FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
YES		YES	
NAME OF DECEASED		NAME OF DECEASED	
JOHN J. SMITH		JOHN J. SMITH	
FATHER'S NAME		MOTHER'S NAME	
JOHN J. SMITH		MARY J. SMITH	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
FARMER		HOUSEWIFE	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
BALTIMORE, MD		BALTIMORE, MD	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
JAN 10 1823		JAN 10 1823	
FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
YES		YES	

02722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		(11) 3401.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1008 W. 42nd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN		First H.		Middle BURRELL		Last			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 28, 1898			
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH March 19 19 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.		11. BIRTHPLACE (State or foreign country) Gloucester, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME John T. Burrell				14. MOTHER'S MAIDEN NAME Eloise Johnson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 217-05-5448		17. INFORMANT Clin. Ex Rec., Vet. Adm. Hospital, Ft. Howard, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RECURRENT GASTRIC CARCINOMA WITH METASTASIS 151X XXXX TO LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastrectomy and Jejunostomy-Operations 5/1/58								INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 14 , 19 59 , to March 19 , 19 59 , and that death occurred at 3:15 P.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE Donald D. Mark		M.D. VAH, FORT HOWARD, MARYLAND		ADDRESS (Street, city or town, state)		DATE SIGNED 3/20/59			
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/21/59		22c. NAME OF CEMETERY OR CREMATORY Gloucester Field Cem.		22d. LOCATION (City, town, or county) (State) Gloucester County, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE NUTTER'S FUNERAL SERVICE, 3004 Clifton Ave.				ADDRESS 3004 Clifton Ave.		24a. REC'D BY REGISTRAR DATE MAR 23 '59			
				24b. REGISTRAR'S SIGNATURE Arthur L. Howard					

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE c. LENGTH OF STAY IN 1b RURAL BALTIMORE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8419 Loch Raven Blvd.		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE d. STREET ADDRESS 8419 D LOCHRAVEN BLVD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FANNIE I BUSCHARDT		4. DATE OF DEATH Month Day Year March 7 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1868
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hamilton Riall		14. MOTHER'S MAIDEN NAME Rose Kelly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Mrs Helen Brown (daughter) same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STROKE...Cerebral Artery Hemorrhage DUE TO (b) Generalized advanced Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH approx 1 hr undet
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John C Hyle		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park
22d. LOCATION (City, town, or county) Baltimore		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto	
24a. REC'D BY REGISTRAR MAR 9 '59		24b. REGISTRAR'S SIGNATURE Charles E. Hume	

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2025. 9. 11. 17.

• *Law*

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John H. Jones, Jr. (continued)

STYON'S... Cathedral Archway Hammering

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22

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02724

CERTIFICATE OF DEATH

Reg. Dist. No.

2755

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1404 Alston Court				d. STREET ADDRESS 1404 Alston Court			
3. NAME OF DECEASED (Type or print) First Robert Middle M. Last Byrd				4. DATE OF DEATH Month March Day 23 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 30, 1896	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret'd) Printer				10b. KIND OF BUSINESS OR INDUSTRY Arthur Thompson Company		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry Byrd				14. MOTHER'S MAIDEN NAME Emma Mueller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-07-8433		17. INFORMANT Mrs. Marie A. Byrd, 1404 Alston Court, Lutherville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1-41							INTERVAL BETWEEN ONSET AND DEATH.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 15, 1958 to March 23, 1959 that I last saw the deceased alive on March 23, 1959 and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lutherville, Md DATE SIGNED 3/25/59							
ACTUAL SIGNATURE George I. Gilmore, MD							
PHYSICIAN'S NAME (Type) GEORGE I. GILMORE, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-27-59		22c. NAME OF CEMETERY OR CREMATORY Garden of Faith Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc, 1217 St. Paul Street				24a. REC'D BY REGISTRAR MAR 30 59		24b. REGISTRAR'S SIGNATURE Christ S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2756

CERTIFICATE OF DEATH

Reg. Dist. No.

02757

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4 W. Overlea Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John L. Caples</u>				4. DATE OF DEATH <u>March 2, 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cab Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Caples</u>				14. MOTHER'S MAIDEN NAME <u>Clara Phillips</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-16-5079</u>		17. INFORMANT <u>Mrs. Ann J. Caples</u> Address <u>4 W. Overlea Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Previous coronary thrombosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>10 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/23, 1947</u> to <u>3/2, 1959</u> , that I last saw the deceased alive on <u>2/16, 1959</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5829 Belair Rd.</u> DATE SIGNED <u>3/4/59</u>							
ACTUAL SIGNATURE <u>D. T. Battaglia</u>		M.D. <u>D.T. Battaglia M.D.</u>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 6, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gardens Of Faith</u>		22d. LOCATION (City, town, or county) (State) <u>Trump Mill Rd. Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassaka Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>MAR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

1910

Name of deceased		Sex		Age		Date of death		Place of death	
John Doe		Male		35		Jan 15 1910		New York City	
Cause of death		Disease		Organ		Nature		Place	
Heart failure		Myocarditis		Heart		Inflammation		New York City	
Occupation		Education		Marital status		Previous illness		Previous surgery	
Teacher		High School		Married		None		None	
Signature of physician		Signature of registrar		Signature of informant		Signature of witness		Signature of undertaker	
J. Smith		A. Jones		B. Brown		C. Green		D. White	
Date of birth		Date of death		Date of burial		Date of cremation		Date of interment	
Jan 1 1910		Jan 15 1910		Jan 20 1910		None		Jan 25 1910	
Place of birth		Place of death		Place of burial		Place of cremation		Place of interment	
New York City		New York City		New York City		None		New York City	
Signature of doctor		Signature of registrar		Signature of informant		Signature of witness		Signature of undertaker	
E. Black		F. Gray		G. White		H. Brown		I. Green	
Date of birth		Date of death		Date of burial		Date of cremation		Date of interment	
Jan 1 1910		Jan 15 1910		Jan 20 1910		None		Jan 25 1910	
Place of birth		Place of death		Place of burial		Place of cremation		Place of interment	
New York City		New York City		New York City		None		New York City	

1910



D. T. Smith M.D.

3589 Main St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2757 CERTIFICATE OF DEATH

Reg. Dist. No.

02726

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baldwin				c. LENGTH OF STAY IN 1b Baldwin			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Leonard Middle Joseph Last Corman				4. DATE OF DEATH Month March Day 22 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 24, 1888	
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist-retired				10b. KIND OF BUSINESS OR INDUSTRY B. & D. Mfg. Co.			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Charles Corman				14. MOTHER'S MAIDEN NAME Elizabeth Pearce			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 216-03-9537		17. INFORMANT Family records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Congestive Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic CVD DUE TO (c) Arteriosclerotic CVD				INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary retention secondary to Ca Prostate				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 0				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 1958 to March 22, 1959 , that I last saw the deceased alive on March 22, 1959 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William A. Tyson M.D.				DATE SIGNED March 22, 1959			
PHYSICIAN'S NAME (Type)				ADDRESS (Street, city or town, state)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Mar. 25, 1959		22c. NAME OF CEMETERY OR CREMATORY St. John's Catholic Cem.	
22d. LOCATION (City, town, or county) (State) Long Green, Maryland				23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland			
24a. REC'D BY REGISTRAR MAR 26 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3787

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH
BOSTON

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES B. BROWN		45		M		W		JAN 15 1880		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
123 MAIN ST. BOSTON		CLOCK REPAIRER		HEART DISEASE		NATURAL		JAN 20 1925		BOSTON	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES B. BROWN		MARY B. BROWN		ELIZABETH B. BROWN		JOHN B. BROWN		HIGH SCHOOL		METHODIST	
BORN		DIED		BORN		DIED		BORN		DIED	
JAN 15 1880		JAN 20 1925		JAN 15 1880		JAN 20 1925		JAN 15 1880		JAN 20 1925	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES B. BROWN		MARY B. BROWN		ELIZABETH B. BROWN		JOHN B. BROWN		HIGH SCHOOL		METHODIST	
BORN		DIED		BORN		DIED		BORN		DIED	
JAN 15 1880		JAN 20 1925		JAN 15 1880		JAN 20 1925		JAN 15 1880		JAN 20 1925	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES B. BROWN		MARY B. BROWN		ELIZABETH B. BROWN		JOHN B. BROWN		HIGH SCHOOL		METHODIST	
BORN		DIED		BORN		DIED		BORN		DIED	
JAN 15 1880		JAN 20 1925		JAN 15 1880		JAN 20 1925		JAN 15 1880		JAN 20 1925	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2758

CERTIFICATE OF DEATH

02727

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 20yrl0mth27dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 3716 Claremont Avenue			
3. NAME OF DECEASED (Type or print) Larry First Chiodo Middle Last				4. DATE OF DEATH Mar. Month 15 Day 19 Year 59			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 21, 1907	
9. AGE (In years last birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Chiodo				14. MOTHER'S MAIDEN NAME Carmella Di DEMASI,			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Metastatic tumor IMMEDIATE CAUSE (a) 200.1 DUE TO Lymphosarcoma, Lymphoblastic type Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from Nov. 5 , 19 58 , to Mar. 15 , 19 59 , that I last saw the deceased alive on Mar. 15 , 19 59 , and that death occurred at 11 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James Donald Drinkard M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-16-59			
PHYSICIAN'S NAME (Type) James Donald Drinkard, M.D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-19-59		22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD. M.D.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler				ADDRESS 901 S. CONKLING ST BALTO, MD.		24a. REC'D BY REGISTRAR DATE 18-59	
				24b. REGISTRAR'S SIGNATURE Charles S. Geiler			

2759

CERTIFICATE OF DEATH

02728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 130 Greenmeadow Drive				d. STREET ADDRESS 130 Greenmeadow Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First IRBY Middle CICERO Last COLE, SR.				4. DATE OF DEATH Month March Day 5 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 5, 1901	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 5 Days 5 Hours 5 Min.		IF UNDER 24 HRS. Months 5 Days 5 Hours 5 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Black & Decker		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Adolphus H. Cole				14. MOTHER'S MAIDEN NAME Sarah Warren			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 230-18-5249			
17. INFORMANT Mrs. Cecil M. Cole, 130 Greenmeadow Dr. Timonium				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Coronary artery Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 DUE TO (c) 420.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1 INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 1956 , to March 5, 1959 , that I last saw the deceased alive on Feb. 17, 1959 , and that death occurred at 9:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1927 York Rd, Timonium DATE SIGNED 3/6/59							
ACTUAL SIGNATURE M. K. Quinn M.D. 1927 York Rd, Timonium							
PHYSICIAN'S NAME (Type) M. K. QUINN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/59		22c. NAME OF CEMETERY OR CREMATORY Fork M.E.		22d. LOCATION (City, town, or county) (State) Fork, Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook-Towson, Inc. Towson, Md.				24a. REC'D BY REGISTRAR MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1940-1941

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		5-1-28		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
4-4-68		MEMPHIS, TENNESSEE		SHOOTING	
TIME OF DEATH		HOURS		MINUTES	
10:15 AM		10		15	
SEX		AGE		MARRIED	
MALE		40		YES	
OCCUPATION		EDUCATION		RELIGION	
MEMBER OF ARMY		HIGH SCHOOL		METHODIST	
MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE	
ARMY		ARMY		ARMY	
1954-1956		1954-1956		1954-1956	
1957-1958		1957-1958		1957-1958	
1959-1960		1959-1960		1959-1960	
1961-1962		1961-1962		1961-1962	
1963-1964		1963-1964		1963-1964	
1965-1966		1965-1966		1965-1966	
1967-1968		1967-1968		1967-1968	
1969-1970		1969-1970		1969-1970	
1971-1972		1971-1972		1971-1972	
1973-1974		1973-1974		1973-1974	
1975-1976		1975-1976		1975-1976	
1977-1978		1977-1978		1977-1978	
1979-1980		1979-1980		1979-1980	
1981-1982		1981-1982		1981-1982	
1983-1984		1983-1984		1983-1984	
1985-1986		1985-1986		1985-1986	
1987-1988		1987-1988		1987-1988	
1989-1990		1989-1990		1989-1990	
1991-1992		1991-1992		1991-1992	
1993-1994		1993-1994		1993-1994	
1995-1996		1995-1996		1995-1996	
1997-1998		1997-1998		1997-1998	
1999-2000		1999-2000		1999-2000	
2001-2002		2001-2002		2001-2002	
2003-2004		2003-2004		2003-2004	
2005-2006		2005-2006		2005-2006	
2007-2008		2007-2008		2007-2008	
2009-2010		2009-2010		2009-2010	
2011-2012		2011-2012		2011-2012	
2013-2014		2013-2014		2013-2014	
2015-2016		2015-2016		2015-2016	
2017-2018		2017-2018		2017-2018	
2019-2020		2019-2020		2019-2020	
2021-2022		2021-2022		2021-2022	
2023-2024		2023-2024		2023-2024	
2025-2026		2025-2026		2025-2026	
2027-2028		2027-2028		2027-2028	
2029-2030		2029-2030		2029-2030	
2031-2032		2031-2032		2031-2032	
2033-2034		2033-2034		2033-2034	
2035-2036		2035-2036		2035-2036	
2037-2038		2037-2038		2037-2038	
2039-2040		2039-2040		2039-2040	
2041-2042		2041-2042		2041-2042	
2043-2044		2043-2044		2043-2044	
2045-2046		2045-2046		2045-2046	
2047-2048		2047-2048		2047-2048	
2049-2050		2049-2050		2049-2050	
2051-2052		2051-2052		2051-2052	
2053-2054		2053-2054		2053-2054	
2055-2056		2055-2056		2055-2056	
2057-2058		2057-2058		2057-2058	
2059-2060		2059-2060		2059-2060	
2061-2062		2061-2062		2061-2062	
2063-2064		2063-2064		2063-2064	
2065-2066		2065-2066		2065-2066	
2067-2068		2067-2068		2067-2068	
2069-2070		2069-2070		2069-2070	
2071-2072		2071-2072		2071-2072	
2073-2074		2073-2074		2073-2074	
2075-2076		2075-2076		2075-2076	
2077-2078		2077-2078		2077-2078	
2079-2080		2079-2080		2079-2080	
2081-2082		2081-2082		2081-2082	
2083-2084		2083-2084		2083-2084	
2085-2086		2085-2086		2085-2086	
2087-2088		2087-2088		2087-2088	
2089-2090		2089-2090		2089-2090	
2091-2092		2091-2092		2091-2092	
2093-2094		2093-2094		2093-2094	
2095-2096		2095-2096		2095-2096	
2097-2098		2097-2098		2097-2098	
2099-2100		2099-2100		2099-2100	
2101-2102		2101-2102		2101-2102	
2103-2104		2103-2104		2103-2104	
2105-2106		2105-2106		2105-2106	
2107-2108		2107-2108		2107-2108	
2109-2110		2109-2110		2109-2110	
2111-2112		2111-2112		2111-2112	
2113-2114		2113-2114		2113-2114	
2115-2116		2115-2116		2115-2116	
2117-2118		2117-2118		2117-2118	
2119-2120		2119-2120		2119-2120	
2121-2122		2121-2122		2121-2122	
2123-2124		2123-2124		2123-2124	
2125-2126		2125-2126		2125-2126	
2127-2128		2127-2128		2127-2128	
2129-2130		2129-2130		2129-2130	
2131-2132		2131-2132		2131-2132	
2133-2134		2133-2134		2133-2134	
2135-2136		2135-2136		2135-2136	
2137-2138		2137-2138		2137-2138	
2139-2140		2139-2140		2139-2140	
2141-2142		2141-2142		2141-2142	
2143-2144		2143-2144		2143-2144	
2145-2146		2145-2146		2145-2146	
2147-2148		2147-2148		2147-2148	
2149-2150		2149-2150		2149-2150	
2151-2152		2151-2152		2151-2152	
2153-2154		2153-2154		2153-2154	
2155-2156		2155-2156		2155-2156	
2157-2158		2157-2158		2157-2158	
2159-2160		2159-2160		2159-2160	
2161-2162		2161-2162		2161-2162	
2163-2164		2163-2164		2163-2164	
2165-2166		2165-2166		2165-2166	
2167-2168		2167-2168		2167-2168	
2169-2170		2169-2170		2169-2170	
2171-2172		2171-2172		2171-2172	
2173-2174		2173-2174		2173-2174	
2175-2176		2175-2176		2175-2176	
2177-2178		2177-2178		2177-2178	
2179-2180		2179-2180		2179-2180	
2181-2182		2181-2182		2181-2182	
2183-2184		2183-2184		2183-2184	
2185-2186		2185-2186		2185-2186	
2187-2188		2187-2188		2187-2188	
2189-2190		2189-2190		2189-2190	
2191-2192		2191-2192		2191-2192	
2193-2194		2193-2194		2193-2194	
2195-2196		2195-2196		2195-2196	
2197-2198		2197-2198		2197-2198	
2199-2200		2199-2200		2199-2200	
2201-2202		2201-2202		2201-2202	
2203-2204		2203-2204		2203-2204	
2205-2206		2205-2206		2205-2206	
2207-2208		2207-2208		2207-2208	
2209-2210		2209-2210		2209-2210	
2211-2212		2211-2212		2211-2212	
2213-2214		2213-2214		2213-2214	
2215-2216		2215-2216		2215-2216	
2217-2218		2217-2218		2217-2218	
2219-2220		2219-2220		2219-2220	
2221-2222		2221-2222		2221-2222	
2223-2224		2223-2224		2223-2224	
2225-2226		2225-2226		2225-2226	
2227-2228		2227-2228		2227-2228	
2229-2230		2229-2230		2229-2230	
2231-2232		2231-2232		2231-2232	
2233-2234		2233-2234		2233-2234	
2235-2236		2235-2236		2235-2236	
2237-2238		2237-2238		2237-2238	
2239-2240		2239-2240		2239-2240	
2241-2242		2241-2242		2241-2242	
2243-2244		2243-2244		2243-2244	
2245-2246		2245-2246		2245-2246	
2247-2248		2247-2248		2247-2248	
2249-2250		2249-2250		2249-2250	
2251-2252		2251-2252		2251-2252	
2253-2254		2253-2254		2253-2254	
2255-2256		2255-2256		2255-2256	
2257-2258		2257-2258		2257-2258	
2259-2260		2259-2260		2259-2260	
2261-2262		2261-2262		2261-2262	
2263-2264		2263-2264		2263-2264	
2265-2266		2265-2266		2265-2266	
2267-2268		2267-2268		2267-2268	
2269-2270		2269-2270		2269-2270	
2271-2272		2271-2272		2271-2272	
2273-2274		2273-2274		2273-2274	
2275-2276		2275-2276		2275-2276	
2277-2278		2277-2278		2277-2278	
2279-2280		2279-2280		2279-2280	
2281-2282		2281-2282		2281-2282	
2283-2284		2283-2284		2283-2284	
2285-2286		2285-2286		2285-2286	
2287-2288		2287-2288		2287-2288	
2289-2290		2289-2290		2289-2290	
2291-2292		2291-2292		2291-2292	
2293-2294		2293-2294		2293-2294	
2295-2296		2295-2296		2295-2296	
2297-2298		2297-2298		2297-2298	
2299-2300		2299-2300		2299-2300	
2301-2302		2301-2302		2301-2302	
2303-2304		2303-2304		2303-2304	
2305-2306		2305-2306		2305-2306	
2307-2308		2307-2308		2307-2308	
2309-2310		2309-2310		2309-2310	
2311-2312		2311-2312		2311-2312	
2313-2314		2313-2314		2313-2314	
2315-2316		2315-2316		2315-2316	
2317-2318		2317-2318		2317-2318	
2319-2320		2319-2320		2319-2320	
2321-2322		2321-2322		2321-2322	
2323-2324		2323-2324		2323-2324	
2325-2326		2325-2326		2325-2326	
2327-2328		2327-2328		2327-2328	
2329-2330		2329-2330		2329-2330	
2331-2332		2331-2332		2331-2332	
2333-2334		2333-2334		2333-2334	
2335-2336		2335-2336		2335-2336	
2337-2338		2337-2338		2337-2338	
2339-234					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2760 CERTIFICATE OF DEATH

Reg. Dist. No.

02730

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 40 Wengate Road				d. STREET ADDRESS 40 Wengate Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KENNETH Middle CONN Last CONN				4. DATE OF DEATH Month March Day 24 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1910	
9. AGE (In years last birthday) 49 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electronic Engineer		10b. KIND OF BUSINESS OR INDUSTRY Westinghouse		11. BIRTHPLACE (State or foreign country) Uniontown, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Conn				14. MOTHER'S MAIDEN NAME Dorothy -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II				16. SOCIAL SECURITY NO. 210-09-1469		17. INFORMANT Mrs. Daphne Jean Conn-40 Wengate Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease with recent congestive heart failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH few minutes over one year						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 17 , 19 59 to March 24 , 19 59 , that I last saw the deceased alive on A.M. of 3/24 , 19 59 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4215 Park Heights Ave. Balto. 15, Md. DATE SIGNED ACTUAL SIGNATURE Ataollah Golpira M.D. PHYSICIAN'S NAME (Type) Ataollah Golpira, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/25/59		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Smithfield, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner ADDRESS Balto - 17, Md.				24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2761

CERTIFICATE OF DEATH

Reg. Dist. No.

02731

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>105 Birdwood Ave.</u>		d. STREET ADDRESS <u>105 Birdwood Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Louise</u> Last <u>Cook</u>		4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4, 1870</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Augustus Hanfmann</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Reinhardt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Miss Bertha Cook</u>		Address <u>105 Birdwood Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Ischemia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Chronic Hypertensive Cardio-Vascular-Renal Disease</u> DUE TO (c) <u>10 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-29-59</u> , 19 <u>41</u> , to <u>3-27-</u> , 19 <u>59</u> , that I lost saw the deceased olive an <u>3-26</u> , 19 <u>59</u> , and that death occurred at <u>900 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>6209 Frederick Ave.</u> <u>3-30-59</u>			
ACTUAL SIGNATURE <u>Wilbur K. Gallagher</u>		M.D. <u>Baltimore-25, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wilbur K. Gallagher</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-31-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose's Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Clopper Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lorley Funeral Home - Catonsville, Md.</u>		ADDRESS <u>Baltimore-25, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll S. Knaus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		Male		35		April 14, 1928		Alton, Illinois		None		Single		White	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
April 4, 1968		10:15 AM		St. Louis, Missouri		Myocardial Infarction		Natural		[Signature]		[Signature]		[Signatures]	
17. COUNTY		18. CITY		19. STATE		20. ZIP CODE		21. HOSPITAL		22. PHYSICIAN		23. REGISTRAR		24. WITNESSES	
St. Louis		St. Louis		Missouri		63101		St. Louis		[Name]		[Name]		[Names]	



1. This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been informed of the cause of death.

2. The cause of death should be stated in as many words as possible, and should include the immediate cause, the intermediate cause, and the remote cause.

3. The manner of death should be stated as either natural, accidental, or homicidal.

4. The signature of the physician or other qualified person who has attended the deceased or who has been informed of the cause of death is required.

5. The signature of the registrar is required.

6. The signature of the witnesses is required.

7. This certificate is to be filed in the office of the registrar of vital statistics.

8. A copy of this certificate is to be sent to the local health department.

9. A copy of this certificate is to be sent to the state health department.

10. A copy of this certificate is to be sent to the federal health department.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G240 4-2-59 et

CERTIFICATE OF DEATH

02732

Reg. Dist. No.

2713

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lansdowne</i>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>51 Lansdowne</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2413 Brunswick Road</i>				d. STREET ADDRESS <i>2413 Brunswick Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Kate</i> First Middle Last <i>Cordery</i>				4. DATE OF DEATH <i>March 22 1959</i> Month Day Year				
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr. 15, 1867</i>		
9. AGE (In years last birthday) <i>91</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <i>London, England</i>		12. CITIZEN OF WHAT COUNTRY? <i>England</i> ✓	
13. FATHER'S NAME <i>George Dicks</i>				14. MOTHER'S MAIDEN NAME <i>?</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 		17. INFORMANT <i>Mr. Frank C. Cordery,</i> Address <i>same</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>Feb. 2, 1959</i> to <i>March 22, 1959</i> , that I last saw the deceased alive on <i>March 20, 1959</i> , and that death occurred at <i>12:10 P.M.</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Florian P. Nadolski</i>				ADDRESS (Street, city or town, state) <i>2703 Hammond Terry Rd Baltimore 27 Md</i>				
PHYSICIAN'S NAME (Type) <i>Florian P. Nadolski</i>				DATE SIGNED 				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/24/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>MAR 26 '59</i>		
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

2762

12233

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr10mth29dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. (28) 16 X - 2	
3. NAME OF DECEASED (Type or print) First Florence Middle Moore Last Couldren		4. DATE OF DEATH Month March Day 13 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1890 (?)
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jeffrey Moore		14. MOTHER'S MAIDEN NAME Mary Bowan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] unknown		16. SOCIAL SECURITY NO. 177-10-0312	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 19 59 to March 13, 19 59 , that I last saw the deceased alive on March 13, 19 59 , and that death occurred at 10:55a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachsler		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 3-13-59	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-59	
22c. NAME OF CEMETERY OR CREMATORY William Cook-Towson, Inc. - Towson, Md.		22d. LOCATION (City, town, or county) (State) Millintown, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook-Towson, Inc. - Towson, Md.		24a. REC'D BY REGISTRAR DATE MAR 16 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02734

2714

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Arbutus	
d. NAME OF HOSPITAL (If not in hospital, give street address) 1035 Maiden Choice Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Barbara Craig		4. DATE OF DEATH Month Day Year March 28, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dressmaker		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U S	
13. FATHER'S NAME George J. XXXXXXXX Goeller		14. MOTHER'S MAIDEN NAME Eva Schrauder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212 32 6999	
17. INFORMANT Eva G. Goeller		Address 1035 Maiden Choice Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchial Asthma DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1945 , to March 28, 1959 , that I last saw the deceased alive on March 28, 1959 , and that death occurred at 11:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. A. Darby, M. D.		ADDRESS (Street, city or town, state) DATE SIGNED 812 Medical Arts Bldg Baltimore 1 Md	
PHYSICIAN'S NAME (Type) William A. Darby, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/31/59	22c. NAME OF CEMETERY OR CREMATORY U.S. National	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Avenue	
24a. REC'D BY REGISTRAR DATE APR 1 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Hubbard	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2768 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02735

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Monkton</i>		c. LENGTH OF STAY IN 1b <i>55</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Monkton Rd</i>				d. STREET ADDRESS <i>1430 E. Penna</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Edward</i> Middle <i>Crump</i> Last <i>Crump</i>				4. DATE OF DEATH Month <i>March</i> Day <i>7</i> Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-15-03</i>	9. AGE (In years last birthday) <i>56</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Porter</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>VA</i>		11. BIRTHPLACE (State or foreign country)		
12. CITIZEN OF WHAT COUNTRY							
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Lucy Crump</i> Address <i>430 E. Penna Rd Towson</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>Charles F. O'Donnell</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-11-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Pleasant Rest</i>		22d. LOCATION (City, town, or county) (State) <i>Towson Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel W. Sullivan Jr</i>				ADDRESS <i>Balto</i>		24a. REC'D BY REGISTRAR <i>Mar 10 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Charles S. Hume</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2764

CERTIFICATE OF DEATH

02736

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 53 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4505 Old Annapolis Road	
3. NAME OF DECEASED (Type or print) First GORDON Middle L Last DaSHIELDS		4. DATE OF DEATH Month March Day 28 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 4, 1923
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR: Months 36 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing Co.	
11. BIRTHPLACE (State or foreign country) Brooklyn, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William DaShields		14. MOTHER'S MAIDEN NAME Louise Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 215-18-7589	
17. INFORMANT Clin. Rec., Vet Adm Hospital, Fort Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKIN'S DISEASE 201X DUE TO GRANULOMA FUNGOIDES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. VA 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 3, 19 59 , to March 28, 19 59 , that he died on the date stated above, and that death occurred at 5:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John W. Crawford M.D.		DATE SIGNED 3/30/59	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH FT HOWARD, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Schwab Funeral Home 2101 Frederick Ave. Balto, Md		24a. REC'D BY REGISTRAR MAR 31 59	
24b. REGISTRAR'S SIGNATURE Arthur J. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2765 CERTIFICATE OF DEATH

02737

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oella</u> OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Logtown</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oella</u> OR TOWN STREET ADDRESS (If rural give location) <u>16 Logtown</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Irene Myra Dayhoff</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 16th., 19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr. 14, 1899</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BURLING IN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Cotton & Woolen Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>William Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Engles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-6363</u>		17. INFORMANT & ADDRESS <u>Mr. Edward Dayhoff Oella, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Condis-Vascular disease</u>						<u>4 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19a. DATE OF OPERATION <u>07</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-4</u> , 19 <u>55</u> , to <u>3-16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-2</u> , 19 <u>59</u> , and that death occurred at <u>9 A.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>George E. Buehner</u>		DATE THEREOF <u>3/19/1959</u>		NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rogers Ave. Ellicott City Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR DATE <u>MAR 19 59</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons</u>		ADDRESS <u>Catonsville, Md.</u>	



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2715

CERTIFICATE OF DEATH

02738

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1212 Leeds Terrace</u>		d. STREET ADDRESS <u>1212 Leeds Terrace</u>	
3. NAME OF DECEASED (Type or print) First <u>Iola</u> Middle <u>M.</u> Last <u>Delosier</u>		4. DATE OF DEATH Month <u>3</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/16/1862</u>
9. AGE (In years last birthday) <u>96</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Delosier</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Mock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>M. John B. Delosier</u>		Address <u>1232 Leeds Terrace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>1955</u> to <u>3-18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-17</u> , 19 <u>59</u> , and that death occurred at <u>5:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl Pass</u>		ADDRESS (Street, city or town, state) <u>400 Wilkens Ave</u> DATE SIGNED <u>3-19-59</u>	
PHYSICIAN'S NAME (Type) <u>I. EARL PASS</u>		<u>400 WILKENS AVE</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/21/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Moran & Son, Baltimore 13 Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 20 1959</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>

2766

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balt.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)				c. LENGTH OF STAY IN 1b 54 Essex (21)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 930 Thompson Blvd				d. STREET ADDRESS 930 Thompson Blvd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Charles Middle Dietrich, Last Dietrich,				4. DATE OF DEATH Month March Day 31 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 13 Days 00 Hours 00 Min.	IF UNDER 24 HRS. Months 13 Days 00 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret'd) Tavern Owner			10b. KIND OF BUSINESS OR INDUSTRY Baltimore		11. BIRTHPLACE (State or foreign country) U.S.A.		
13. FATHER'S NAME John Dietrich				14. MOTHER'S MAIDEN NAME Anna (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Daisy M. Dietrich, 930 Thompson Blvd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchogenic carcinoma DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 13 mo. 15 mo.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Maryland	
21. I certify that I attended the deceased from 9/2 , 19 53 , to 3/31 , 19 59 , that I last saw the deceased alive on 3/24 , 19 59 , and that death occurred at 10:00 P. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph Miceli				ADDRESS (Street, city or town, state) 108 S. Taylor Avenue			
DATE SIGNED 4/3/59							
PHYSICIAN'S NAME (Type) Joseph Miceli M.D.				108 S. Taylor Ave. Baltimore 21. Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-4-59		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE April 6 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2767

CERTIFICATE OF DEATH

02740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 61 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ARTHUR Middle W. Last DIEZEL				4. DATE OF DEATH Month March Day 18 Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH JULY 25, 1914	
9. AGE (In years last birthday) yrs. 44		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assignment Clerk		10b. KIND OF BUSINESS OR INDUSTRY BOASI		11. BIRTHPLACE (State or foreign country) SHAMOKIN	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HARRY A DIEZEL		14. MOTHER'S MAIDEN NAME ROSEANNE FISHER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-11	
16. SOCIAL SECURITY NO. 178-05-2498		17. INFORMANT CLIN REC VET ADM HOSP		Address FT HOWARD MARYLAND		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, ACUTE 430.1 XXXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PYELONEPHRITIS, CHRONIC, BILATERAL DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SUPPURATIVE CYSTOTOMY - Operation - March 1959	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from January 16 , 1959, to March 18 , 1959, and that death occurred at 11:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
ACTUAL SIGNATURE John W. Crawford M.D.		PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH, FORT HOWARD, MARYLAND		3/19/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-23-59		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, 6009 Harford Rd.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 23 59		24b. REGISTRAR'S SIGNATURE Edna A. Haines	

WM. COOK-BLIGHT INC 6009 HARFORD RD Baltimore Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

Form with fields for Name, Sex, Age, Race, Birth Date, Birth Place, and other personal information.

Form with fields for Cause of Death, Place of Death, and other medical information.

Form with fields for Date of Death, Time of Death, and other details.

Form with fields for Signature, Date, and other administrative information.

Form with fields for Registrar, Date, and other administrative information.

Form with fields for Registrar, Date, and other administrative information.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2768

CERTIFICATE OF DEATH

Reg. Dist. No.

02741

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 3Yr. 10Mo. 27D	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Sheppard & Enoch Pratt Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
f. STREET ADDRESS 2232 Que Street, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Katherine Merron Dishaw		4. DATE OF DEATH Month March Day 26 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1881
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Hugh Merron		14. MOTHER'S MAIDEN NAME Mary LaChapelle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 7 yrs 5 yr + 11			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome & Cerebral arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 29, 1955 to March 26, 1959 , that I last saw the deceased alive on March 25, 1959 , and that death occurred at 9:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Sheppard and Enoch Pratt Hospital DATE SIGNED 3/28/59			
ACTUAL SIGNATURE W. W. Elgin		M.D. W. W. Elgin, M. D.	
PHYSICIAN'S NAME (Type) W. W. Elgin, M. D.		Towson 4, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 3-27-59	
22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Massena, New York	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAR 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

3128

4574

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: [illegible]
DATE: [illegible]
TIME: [illegible]
PLACE: [illegible]
CAUSE: [illegible]
SIGNATURE: [illegible]



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02742

2769

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 3yr6mth26dys			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, hr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 2211 Taylor Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle W. Last Dobe				4. DATE OF DEATH Month MARCH Day 27 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 15, 1875	
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Henry Heinz				14. MOTHER'S MAIDEN NAME Amie Ottaviano Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterioscl. Cardio Vas. Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 26, 1959 to March 27, 1959 , that I last saw the deceased alive on 3/27/59 , 1959, and that death occurred at 4:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachslar M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3/27/59			
PHYSICIAN'S NAME (Type) STELLA WACHSLER				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-30-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) East North Avenue Balto	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Ruth Inc - 1735 Hanford St				24a. REC'D BY REGISTRAR DATE MAR 31 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Place of birth: <u>MASSACHUSETTS</u></p>	
<p>5. Date of death: <u>1975</u></p>		<p>6. Place of death: <u>MASSACHUSETTS</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of registration: <u>1975</u></p>		<p>12. Place of registration: <u>MASSACHUSETTS</u></p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02744

2771

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. LENGTH OF STAY IN 1b X Woodlawn			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5508 Windsor Mill Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN BROOKE DUVALL, Sr.				4. DATE OF DEATH Month March Day 4 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1879	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Vice Pres. Balto. Transit				10b. KIND OF BUSINESS OR INDUSTRY St. Margaretss Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Duvall				14. MOTHER'S MAIDEN NAME Mary Stallings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-05-9670		17. INFORMANT Matilda E. Duvall - 5508 Windsor Mill Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (Recurrent) DUE TO Arterio-Sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 yrs. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec. 22 , 19 42 , to March - 4 , 19 59 , that I last saw the deceased alive on March 3rd , 19 59 , and that death occurred at 4:57 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4108 Liberty St. Ave. Balto. 7 mp. 36-59 DATE SIGNED 3-6-59							
ACTUAL SIGNATURE Earl L. Chambers M.D.				PHYSICIAN'S NAME (Type) Earl L. Chambers 4108 Liberty St. Ave. - Balto. 7 mp.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/6/1959		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS 4600 Liberty Hghts. Ave.				24a. REC'D BY REGISTRAR DATE MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Rev. Health

1. Name of Deceased		2. Sex		3. Age		4. Date of Birth		5. Date of Death		6. Place of Death		7. Cause of Death		8. Signature of Physician		9. Signature of Registrar		10. Date of Registration	
JOHN J. WILSON		Male		45		1910		1955		Home		Heart Disease		[Signature]		[Signature]		1955	
11. Name of Informant		12. Relationship		13. Address		14. City		15. State		16. Zip		17. Telephone		18. Signature of Informant		19. Signature of Registrar		20. Date of Registration	
JOHN J. WILSON		Son		1234 Main St.		Baltimore		Maryland		21201		[Phone]		[Signature]		[Signature]		1955	
21. Name of Informant		22. Relationship		23. Address		24. City		25. State		26. Zip		27. Telephone		28. Signature of Informant		29. Signature of Registrar		30. Date of Registration	
JOHN J. WILSON		Son		1234 Main St.		Baltimore		Maryland		21201		[Phone]		[Signature]		[Signature]		1955	

2772

VS. A15ME
SM 2/57

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in ~~any~~ present within 72 hours after death.

1. Name of Deceased: _____
 2. Date of Death: _____
 3. Place of Death: _____
 4. Age: _____
 5. Sex: _____
 6. Race: _____
 7. Occupation: _____
 8. Education: _____
 9. Marital Status: _____
 10. Cause of Death: _____
 11. Date of Burial: _____
 12. Place of Burial: _____
 13. Name of Burial Place: _____
 14. Name of Minister: _____
 15. Name of Undertaker: _____
 16. Name of Physician: _____
 17. Name of Coroner: _____
 18. Name of Registrar: _____
 19. Name of Clerk: _____
 20. Name of Nurse: _____
 21. Name of Doctor: _____
 22. Name of Pharmacist: _____
 23. Name of Dentist: _____
 24. Name of Veterinarian: _____
 25. Name of Engineer: _____
 26. Name of Lawyer: _____
 27. Name of Judge: _____
 28. Name of Mayor: _____
 29. Name of Governor: _____
 30. Name of President: _____

DEPARTMENT OF HEALTH
STATE OF MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00 47

1. Name of Deceased: _____
 2. Date of Death: _____
 3. Place of Death: _____
 4. Age: _____
 5. Sex: _____
 6. Race: _____
 7. Occupation: _____
 8. Education: _____
 9. Marital Status: _____
 10. Cause of Death: _____
 11. Date of Burial: _____
 12. Place of Burial: _____
 13. Name of Burial Place: _____
 14. Name of Minister: _____
 15. Name of Undertaker: _____
 16. Name of Physician: _____
 17. Name of Coroner: _____
 18. Name of Registrar: _____
 19. Name of Clerk: _____
 20. Name of Nurse: _____
 21. Name of Doctor: _____
 22. Name of Pharmacist: _____
 23. Name of Dentist: _____
 24. Name of Veterinarian: _____
 25. Name of Engineer: _____
 26. Name of Lawyer: _____
 27. Name of Judge: _____
 28. Name of Mayor: _____
 29. Name of Governor: _____
 30. Name of President: _____

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Items 2,7 FilmG239 3-9-59 et
2773
CERTIFICATE OF DEATH

02746

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Robb Nursing Home				c. LENGTH OF STAY IN 1b 1 yr			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4501 ESSEX Rd - 7				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AGNES MOORE EGGERTON				4. DATE OF DEATH MAR 2 1959			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 17, 1881	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COMPANION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ALFRED BYRD MOORE				14. MOTHER'S MAIDEN NAME JOSEPHINE BONAPARTE CONWAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-26-9802		17. INFORMANT G.E. ODENHEIMER 619 Suddbrook Rd. Pikesville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 4 hrs Year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 20, 1958 , to Feb Mar 2, 1959 , that I last saw the deceased alive on Mar 2, 1959 , and that death occurred at 4:00 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Kaverly S. Green, Jr. M.D.				ADDRESS (Street, city or town, state) Pikesville 8, MD			
DATE SIGNED Mar 2, 1959							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-4-59		22c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE H.W. JENKINS & SONS Co. 4905 YORK RD.				24a. REC'D BY REGISTRAR DATE MAR 3 '59		24b. REGISTRAR'S SIGNATURE John S. Hume	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2774

CERTIFICATE OF DEATH

02747

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 658 WASHINGTON BLVD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HOWARD DRAKE EISENHOWER		4. DATE OF DEATH Month Day Year MARCH 5 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 6, 1898
9. AGE (In years last birthday) yrs. 61		10. IF UNDER 1 YEAR Months Days Hours Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LOCOMOTIVE FIREMAN		10b. KIND OF BUSINESS OR INDUSTRY RAILROAD	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DANIEL EISENHOWER		14. MOTHER'S MAIDEN NAME JENNIE DRAKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 215-18-7760	
17. INFORMANT Hospital Records, Mt. Wilson State Hosp.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/20 , 19 59 , to 3/5 , 19 59 , that I last saw the deceased alive on 3/5 , 19 59 , and that death occurred at 1:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED			
ACTUAL SIGNATURE W. Newcomer		M.D. Superintendent	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 3-9-59	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery, Baltimore, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Frank D. Newell, Baltimore, Md.		24a. REC'D BY REGISTRAR DATE MAR 13 1959	24b. REGISTRAR'S SIGNATURE Charles E. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2, and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPT. OF HEALTH
BALTIMORE

Form with multiple lines for text entry, including fields for name, date, and location. The form is oriented vertically on the page.



Vertical text on the right margin, likely a date or reference number, oriented vertically.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02748

2716

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b 4 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4202 Leeds Avenue				d. STREET ADDRESS 4202 Leeds Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Oatha Middle Thomas Last Ellis		4. DATE OF DEATH Month March Day 29 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1885		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance man - retired		10b. KIND OF BUSINESS OR INDUSTRY real estate		11. BIRTHPLACE (State or foreign country) Warrenton, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Ellis				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-07-6584		17. INFORMANT Alma C. Ellis, wife Address 4202 Leeds Avenue 29			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/3 , 19 49 , to 3/29 , 19 59 , that I last saw the deceased alive on 3/27 , 19 59 , and that death occurred at 2 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1227 Wash. Blvd. DATE SIGNED 3/31/59 ACTUAL SIGNATURE John P. Urlock Jr. M.D. 1227 Wash. Blvd. PHYSICIAN'S NAME (Type) John P. Urlock, Jr. 1227 Washington Blvd.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Russell Thomas - 4204 Leeds Avenue				24a. REC'D BY REGISTRAR DATE APR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2775

CERTIFICATE OF DEATH

02749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklintown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklintown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5907 Cecil Ave.</u>		f. STREET ADDRESS <u>5907 Cecil Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SALLIE</u> Middle <u>MAY</u> Last <u>ELSEROAD</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>15</u> Year <u>19 59</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 8, 1882</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md.</u>	
13. FATHER'S NAME <u>Nathan Porter</u>		14. MOTHER'S MAIDEN NAME <u>? Cavey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Herbert Reynolds-222 E. Medwick Garth #28</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, left breast</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>170x</u> DUE TO (c) <u>170x</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>March 15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 15</u> , 19 <u>59</u> , and that death occurred at <u>2:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. C. MacLaughlin</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4508 Edmondson Village 3/17/59</u>	
PHYSICIAN'S NAME (Type) <u>D. C. MacLaughlin, M.D.</u>		<u>4508 Edmondson Village Balto 29, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Baltimore, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>			

2776

CERTIFICATE OF DEATH

02750

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks (rural)		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tanyard Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lester Chilcoat Ensor		4. DATE OF DEATH Month Day Year 3-12-59 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1894
9. AGE (In years last birthday) yrs. 64		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) owner operator		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mitchell Ensor		14. MOTHER'S MAIDEN NAME Ozella Chilcoat	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-34-5995	
17. INFORMANT Jodie B. Ensor		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 9 mos.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 6-30-58 , 19__, to 3-12-59 , 19__, that I last saw the deceased alive on 12-24-58 , 19__, and that death occurred at 9:30P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 6 Hanover Rd. 3-12-59			
ACTUAL SIGNATURE D. D. Caples		M.D. Reisterstown, Md.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-16-59	22c. NAME OF CEMETERY OR CREMATORY Black Rock	22d. LOCATION (City, town, or county) (State) Butler, Md.
23. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks		24a. REC'D BY REGISTRAR DATE MAR 18 '59	
ADDRESS 622 York Rd., Towson 4, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

62750

CENTRAL BANK OF CANADA

2770

Baltimore

Maryland

Baltimore

Spokane (Wash.)

Idaho

Spokane (Wash.)

Tampa, Fla.

Tampa, Fla.

3-12-32

Lester Clifford Brown

Ch

4-10-1924

white

male

U.S.A.

Maryland

farm

owner operator

Gaelle Clifford

Mitchell Brown

above

320-34-2922 Leslie E. Brown

no

CHIEF OF POLICE

12

1 4 M 50 1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2778

CERTIFICATE OF DEATH

02752

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 459 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS Box 44	
3. NAME OF DECEASED (Type or print) JAMES B. FITCH		First Middle Last		4. DATE OF DEATH March 14 19 59		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 8, 1916	
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Garage		11. BIRTHPLACE (State or foreign country) Stemmers Run,	
12. CITIZEN OF WHAT COUNTRY? Maryland							
13. FATHER'S NAME Thomas Fitch				14. MOTHER'S MAIDEN NAME Emma McLane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II 217-05-7512		17. INFORMANT Clin Records, Vet. Adm. Hosp. Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONVULSIVE DISORDER DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASTROCYTOMA DUE TO (c) UNKNOWN						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from December 10, 1957 , to March 14, 1959 , and that death occurred at 3:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Armen Bogosian M.D.							
PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M. D.				VAH, Fort Howard, Maryland 3/14/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-18-1959		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		22d. LOCATION (City, town, or county) (State) 8420 Belair Rd. Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LA SAHN FUNERAL HOME, 7401 Belair Rd. Balto. Md.				24a. REC'D BY REGISTRAR MAR 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2779

CERTIFICATE OF DEATH

02753

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				c. LENGTH OF STAY IN 1b 60 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 212 W. Seminary Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				4. DATE OF DEATH Month 3 Day 25 Year 59			
3. NAME OF DECEASED (Type or print) First Middle Last John Pinkney Frantz, Sr.				5. SEX male 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 8-5-1869				9. AGE (In years last birthday) 89 IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) insurance sales				10b. KIND OF BUSINESS OR INDUSTRY self employed			
11. BIRTHPLACE (State or foreign country) Wyoming				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John H. Frantz				14. MOTHER'S MAIDEN NAME Louisa Sewall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-32-7887			
17. INFORMANT Louise S. Frantz				Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Arteriosclerosis, General. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Unk DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5-29 , 19 52 , to 3-25 , 19 59 , that I last saw the deceased alive on 3-25 , 19 59 , and that death occurred at 10 A .M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Bennett A. Stoen				ADDRESS (Street, city or town, State) 19 W. Seminary Ave., Lutherville, Md.			
DATE SIGNED 3/26/59				PHYSICIAN'S NAME (Type) Bennett A. Stoen			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-27-59			
22c. NAME OF CEMETERY OR CREMATORY St. James Episcopal				22d. LOCATION (City, town, or county) (State) Monkton, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks				ADDRESS 622 York Rd., Towson 4, Md.			
24a. REC'D BY REGISTRAR MAR 30 '59				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please receive carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100752

CERTIFICATE OF MARRIAGE

100752

Baltimore

Baltimore

Baltimore

Lutherville

Lutherville

to

212 W. Seminary Ave. 212 W. Seminary Ave.

John Timothy Francis, Sr.

100752

White Male

8-2-1922

Insurance Sales self-employed Working

John T. Francis

212-22-2827 Lutherville, Md. above

212 W. Seminary Ave., Lutherville, Md.

212 W. Seminary Ave., Lutherville, Md.

602 York St., Lutherville, Md.

2780

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillie G. Frazier		4. DATE OF DEATH Month March Day 26 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1870
9. AGE (In years lost birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Missionary Work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Peter T. Pilchard		14. MOTHER'S MAIDEN NAME Dollie Riffin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT George Pilchard 2505 Whitney Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1, 1953 to 3/26, 1959 , that I last saw the deceased alive on 3/23, 1959 , and that death occurred at 6:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4605 Edmondson Ave DATE SIGNED 3/27/59			
ACTUAL SIGNATURE Cliff Ratliff, Jr. M.D.		PHYSICIAN'S NAME (Type) Dr. Cliff Ratliff, Jr. 4605 Edmondson Ave.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 30, 1959	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Place		24a. REC'D BY REGISTRAR DATE MAR 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur J. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

Page One

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1875		New York City	
Cause of Death		Disease		Organ		Site		Nature	
Heart Disease		Coronary Artery		Sclerosis		Atherosclerosis		Obstructive	
Date of Death		Time of Death		Place of Death		Physician		Signature	
Jan 15, 1920		10:00 AM		Home		Dr. J. Smith		[Signature]	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Date	
Catholic Cemetery		Jan 18, 1920		10:00 AM		Catholic Cemetery		Jan 18, 1920	
Funeral Home		Funeral Date		Funeral Time		Funeral Place		Funeral Date	
John Doe & Co.		Jan 16, 1920		10:00 AM		Catholic Cemetery		Jan 18, 1920	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Date	
Catholic Cemetery		Jan 18, 1920		10:00 AM		Catholic Cemetery		Jan 18, 1920	
Funeral Home		Funeral Date		Funeral Time		Funeral Place		Funeral Date	
John Doe & Co.		Jan 16, 1920		10:00 AM		Catholic Cemetery		Jan 18, 1920	

1

2781

item 1 Film 241 4-6-59 et

CERTIFICATE OF DEATH

02755

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Balto</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hamstead</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RED Daughter's home</i>				d. STREET ADDRESS <i>108 Smithwood</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>MAUDES FREELAND</i> First Middle Last				4. DATE OF DEATH <i>3/23/59</i> Month Day Year			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/5/81</i>	9. AGE (In years lost birthday) <i>77</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Edmund Stables</i>				14. MOTHER'S MAIDEN NAME <i>Rebecca Cuddy</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i>		17. INFORMANT <i>Stables Freeland</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Bronchitis</i> DUE TO (c) <i>Parkinson's Disease</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i> <i>3 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>10/16</i> , 19 <i>58</i> , to <i>March 23</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>March 23</i> , 19 <i>59</i> , and that death occurred at <i>4P</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W H Foard</i>				ADDRESS (Street, city or town, state) <i>Manchester md</i>			
PHYSICIAN'S NAME (Type) <i>W H Foard M.D.</i>				DATE SIGNED <i>3/24/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/26/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Torrance</i>		22d. LOCATION (City, town, or county) <i>Balto Co</i> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mar Nat + Son</i> ADDRESS <i>28 Catonsville Md</i>				24a. REC'D BY REGISTRAR DATE <i>MAR 30 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. King</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2782

CERTIFICATE OF DEATH

02756

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto Co</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House of Times</u>		d. STREET ADDRESS <u>29 Trusting ave</u>		
3. NAME OF DECEASED (Type or print) <u>Josephine</u> First <u>a</u> Middle <u>a</u> Last <u>Garber</u>		4. DATE OF DEATH <u>3</u> Month <u>22</u> Day <u>19</u> Year <u>59</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/1866</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>		
11. BIRTH PLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>Thomas O Lindsay</u>		14. MOTHER'S MAIDEN NAME <u>Laura Cashow</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> Address <u>Mrs. Clara Tucker</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> <u>Coronary Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Diabetes</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1531</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>9/6</u> , 19 <u>58</u> , to <u>3/22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/22</u> , 19 <u>59</u> , and that death occurred at <u>2:15</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED <u>3/22/59</u>				
ACTUAL SIGNATURE <u>Wilmer K. Gallager</u> M.D.		PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u> <u>Baltimore 28, Md.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>3/24/59</u>	<u>Linganore</u>	<u>Frederick Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Hall & Son</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DATE MAR 26 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		

2783

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson Timonium				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 Belfast Road				/d. STREET ADDRESS 17 Belfast Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BETTY Middle D. Last GARRETT				4. DATE OF DEATH Month March Day 11 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 7, 1883		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel H. Molesworth				14. MOTHER'S MAIDEN NAME Memie Daffin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None		17. INFORMANT Family records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						INTERVAL BETWEEN ONSET AND DEATH 1 hour ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 19, 1959 , to March 11, 1959 , that I last saw the deceased alive on March 9, 1959 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George T. Gilmore M.D. Lutherville, Md 3/10/59							
ACTUAL SIGNATURE George T. Gilmore		PHYSICIAN'S NAME (Type) GEORGE T. GILMORE, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 14, 1959		22c. NAME OF CEMETERY OR CREMATORY Vernon Methodist Cemetery		22d. LOCATION (City, town, or county) (State) White Hall, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland				24a. REC'D BY REGISTRAR DATE MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DAYLAND STATE DEPARTMENT OF HEALTH—BATHING

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02758

Reg. Dist. No.

2784

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Balts.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 55 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7912 Ruxway		d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mrs. Eva Bryan Garrett First Middle Last		4. DATE OF DEATH Month Day Year March 25 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1879
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ? Bryan		14. MOTHER'S MAIDEN NAME Emma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-30-4802	
17. INFORMANT Mrs Robert T. Garrett, 5004 La Salle Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH SEV. YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/11 , 19 58 , to MAR 26 , 19 59 , that I last saw the deceased alive on MAR 23 , 19 59 , and that death occurred at 8 A . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 17 W. PENNA. AV DATE SIGNED 3/26/59 ACTUAL SIGNATURE T. C. Siwinski M.D. TOWSON 4 MD PHYSICIAN'S NAME (Type) T. C. SIWINSKI			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/59	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Hartford Road #14 ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 7 hours after death.

VS A15 (4)
15M 9/55

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508-05-220

02759

2785

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 4 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS 3013 WESTFIELD AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GENEVA Middle N. Last GARTSIDE				4. DATE OF DEATH Month MARCH Day 13 Year 1959			
5. SEX FE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-12-1887	
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REG. NURSE				10b. KIND OF BUSINESS OR INDUSTRY PUBLIC HEALTH NURSE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME DR. JOSEPH T. NELSON				14. MOTHER'S MAIDEN NAME MARY IRLAND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Frank L. Smith Jr. - Cockeysville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arterio Sclerotic Cardio (c) Vascular disease				INTERVAL BETWEEN ONSET AND DEATH 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11/29 , 19 54 , to 3/12 , 19 59 , that I last saw the deceased alive on 3/12 , 19 59 , and that death occurred at 4:47 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Walter T. Kees				ADDRESS (Street, city or town, state) Cockeysville, Md.			
PHYSICIAN'S NAME (Type) Walter T. Kees				DATE SIGNED 3/13/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-16-59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thoms	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. PLACE OF DEATH BALTIMORE, MARYLAND	
3. SEX MALE		4. AGE 35	
5. RACE WHITE		6. DATE OF DEATH JUNE 28, 1968	
7. TIME OF DEATH 10:00 AM		8. PLACE OF DEATH BALTIMORE, MARYLAND	
9. CAUSE OF DEATH HEART DISEASE		10. MANNER OF DEATH NATURAL	
11. ICD-9 CODE 410.9		12. ICD-9 CODE 01	
13. ICD-9 CODE 01		14. ICD-9 CODE 01	
15. ICD-9 CODE 01		16. ICD-9 CODE 01	
17. ICD-9 CODE 01		18. ICD-9 CODE 01	
19. ICD-9 CODE 01		20. ICD-9 CODE 01	
21. ICD-9 CODE 01		22. ICD-9 CODE 01	
23. ICD-9 CODE 01		24. ICD-9 CODE 01	
25. ICD-9 CODE 01		26. ICD-9 CODE 01	
27. ICD-9 CODE 01		28. ICD-9 CODE 01	
29. ICD-9 CODE 01		30. ICD-9 CODE 01	
31. ICD-9 CODE 01		32. ICD-9 CODE 01	
33. ICD-9 CODE 01		34. ICD-9 CODE 01	
35. ICD-9 CODE 01		36. ICD-9 CODE 01	
37. ICD-9 CODE 01		38. ICD-9 CODE 01	
39. ICD-9 CODE 01		40. ICD-9 CODE 01	
41. ICD-9 CODE 01		42. ICD-9 CODE 01	
43. ICD-9 CODE 01		44. ICD-9 CODE 01	
45. ICD-9 CODE 01		46. ICD-9 CODE 01	
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83. ICD-9 CODE 01		84. ICD-9 CODE 01	
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89. ICD-9 CODE 01		90. ICD-9 CODE 01	
91. ICD-9 CODE 01		92. ICD-9 CODE 01	
93. ICD-9 CODE 01		94. ICD-9 CODE 01	
95. ICD-9 CODE 01		96. ICD-9 CODE 01	
97. ICD-9 CODE 01		98. ICD-9 CODE 01	
99. ICD-9 CODE 01		100. ICD-9 CODE 01	

1. NAME OF DECEASED
JAMES EARL RAY

2. PLACE OF DEATH
BALTIMORE, MARYLAND

3. SEX
MALE

4. AGE
35

5. RACE
WHITE

6. DATE OF DEATH
JUNE 28, 1968

7. TIME OF DEATH
10:00 AM

8. PLACE OF DEATH
BALTIMORE, MARYLAND

9. CAUSE OF DEATH
HEART DISEASE

10. MANNER OF DEATH
NATURAL

11. ICD-9 CODE
410.9

12. ICD-9 CODE
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13. ICD-9 CODE
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14. ICD-9 CODE
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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2786

CERTIFICATE OF DEATH

Reg. Dist. No.

02760

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 52 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 908 Bardswell Ave		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville d. STREET ADDRESS 1 908 Bardswell Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Idora Middle Geppi Last Idora		4. DATE OF DEATH Month March Day 26 Year 19 59	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1911
9. AGE (In years last birthday) 47		10. IF UNDER 1 YEAR Months 11 Days 26 Hours 15 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Hutzlers	
11. BIRTHPLACE (State or foreign country) Calif.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Antonio D. Geppi		14. MOTHER'S MAIDEN NAME Anna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Miss Anna Geppi, 908 Bardswell Ave	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) With Metastases to DUE TO (c) Brain		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 19 59 to March 26 59 , that I last saw the deceased alive on March 26 59 , and that death occurred at 9:45 M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE M Paul Byerly PHYSICIAN'S NAME (Type) M Paul Byerly		M.D. 3033 W North A Balto Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/59	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE MAR 30 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

CITY OF BALTIMORE

3786

Baltimore

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2787

CERTIFICATE OF DEATH

Reg. Dist. No.

02761

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>George A. Gill</u> First Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-22-76</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Harb Electric Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSPECTOR</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jacob R. Gill</u>		14. MOTHER'S MAIDEN NAME <u>Sarah / SARAH NAYLOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>212-05-3303</u>	
17. INFORMANT <u>Wife</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>malnutrition</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-16-59</u> , 19 <u>59</u> , to <u>3-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-16-59</u> , 19 <u>59</u> , and that death occurred at <u>5 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>3/26/59</u>	
PHYSICIAN'S NAME (Type) <u>STELLA NACHSLER</u>		<u>Spring Grove State Hospital</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SATER'S CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>Lutherville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Thompson</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hume</u>

70. 113

25/02/0

CERTIFICATE OF DEATH

02762

Reg. Dist. No.

2788

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) Stella Maris Hospice		d. STREET ADDRESS 1335 Lombard AVE	
3. NAME OF DECEASED (Type or print) First Emil Middle Gissler Last 4. DATE OF DEATH Month March Day 14 Year 1959		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/19/1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 87 yrs.
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Gissler		14. MOTHER'S MAIDEN NAME Mary Wussler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Renal DUE TO Renal (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 15 Days 25 Days 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Oct 1953 to March 14, 1959 that I last saw the deceased alive on March 13, 1959 and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell M.D.		ADDRESS (Street, city or town, state) 7501 York Rd DATE SIGNED 3/14/59	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell, M.D.		Towson Md	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 3/16/59	22c. NAME OF CEMETERY OR CREMATORY Meadowridge	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Leonard Plunk		ADDRESS 5305 Harford	24a. REC'D BY REGISTRAR DATE MAR 18 '59
		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02763

2789

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 02X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OSCAR Middle JESSE Last GROFF		4. DATE OF DEATH Month 3 Day 21 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-1894	9. AGE (In years last birthday) yrs. 64	10. IF UNDER 1 YEAR Months 3 Days 21 Hours 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMBALMER		10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA		11. BIRTHPLACE (State or foreign country) U.S.A	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME AMOS GROFF		14. MOTHER'S MAIDEN NAME EFFIE JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1-12-037213		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY TUBERCULOSIS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3-21	
20f. (City or town) Balto		20g. (County) Balto		20h. (State) MD	
21. I certify that I attended the deceased from 2-12-58 19 to 3-21 1959, that I last saw the deceased alive on 3-21- 1959, and that death occurred at 8:07 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7-21-59					
ACTUAL SIGNATURE William Newcomer		M.D. Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-24-59		22c. NAME OF CEMETERY OR CREMATORY Balto National	
22d. LOCATION (City, town, or county) Balto		(State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis		ADDRESS 2100 Eutaw Place		24a. REC'D BY REGISTRAR MAR 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hunt					

CERTIFICATE OF DEATH

5722

1912

NAME OF DECEASED

WILLIAM J. COOPER

DATE OF DEATH

APRIL 10, 1912

AGE

45 YEARS

SEX

MALE

PLACE OF DEATH

NEW YORK CITY

CAUSE OF DEATH

HEART DISEASE

MYOCARDIAL INFARCTION

CHOLESTEROL

THROMBOSIS

OF CORONARY ARTERY

OF LEFT VENTRICLE

OF HEART

OF CORONARY ARTERY

OF LEFT VENTRICLE

OF HEART

OF CORONARY ARTERY

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OF CORONARY ARTERY

OF LEFT VENTRICLE

OF HEART

OF CORONARY ARTERY

OF LEFT VENTRICLE

OF HEART

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2706

CERTIFICATE OF DEATH

02764

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b <u>56 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7873 ST. BRIDGETS LANE</u>				d. STREET ADDRESS <u>7873 ST. BRIDGETS LANE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARIA</u> Middle <u>LE</u> Last <u>GROS</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 30, 1882</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>BELGIUM</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>HUGUST LIPPENS</u>				14. MOTHER'S MAIDEN NAME <u>EUGENIE SPITTEL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u> </u>			
INFORMANT <u>HUBERT LE GROS</u>				Address <u>1411 TYLER RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Heart disease</u> DUE TO (c) <u>Generalized Arterio Sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>5 yrs</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>3-16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-17-59</u> , 19 <u> </u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Jack C Collins</u>				ADDRESS (Street, city or town, state) <u>2 Kensington Baltimore MD</u>			
DATE <u>3-17-59</u>				DATE <u> </u>			
PHYSICIAN'S NAME (Type) <u>Jack C Collins</u>				BALTIMORE 2 - <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MORROW RIDGE</u>		22d. LOCATION (City, town, or county) (State) <u>DORSEY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME - DUNDALK MD</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

10370

3708



10370



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 239 3-16-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 02765

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3yr9mth24dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
3. NAME OF DECEASED (Type or print) First Howard Middle Haines Last Haines		4. DATE OF DEATH Month March Day 5 Year 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 1879
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Keefer		14. MOTHER'S MAIDEN NAME Martha J.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 218-05-3465A	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 23, 1959 , to March 5, 1959 , that I last saw the deceased alive on March 5, 1959 , and that death occurred at 5:40a M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stella Wachslar		ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 3-5-59	
PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-11-59	22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAR 10 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraw			

1. The first step in the process of creating a new product is to identify a market need. This involves conducting market research to understand the preferences and behaviors of potential customers. Once a need is identified, the next step is to develop a concept that addresses this need. This concept should be unique, valuable, and feasible. The third step is to create a prototype, which is a preliminary version of the product used to test the concept and gather feedback. The fourth step is to conduct a feasibility study, which evaluates the technical, financial, and operational aspects of the product. The final step is to develop a business plan, which outlines the strategy for launching and marketing the product, as well as the financial projections and funding requirements.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2791

CERTIFICATE OF DEATH

02766

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) BEULAH TRUE HEART HALL			2. DATE OF DEATH March 29, 1959		
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore (12)			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY Balto. Co.		
B. FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE COUNTY 246 Blenheim Road			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) X Baltimore		
D. Length of stay in Baltimore 6 yrs			E. STREET ADDRESS (If rural, give location) 246 Blenheim Road		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct 2, 1871	9. AGE (In years last birthday) 87	10. Under 1 Year Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore
13. FATHER'S NAME William Henry Trueheart			14. MOTHER'S MAIDEN NAME Lucy White		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No			17. INFORMANT ADDRESS Miss Lucy Bosley Hall. Same.		
18. 422.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute Cardiac Failure			CAUSE OF DEATH (A) Acute Cardiac Failure DUE TO (B) Arteriosclerotic Cardiac DUE TO (C) Cholest		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			INTERVAL BETWEEN ONSET AND DEATH 2 days		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Jan 1 - 1959 to Mar 29 - 1959 , that (I) (we) last saw the deceased alive on Mar 29 - 1959 , and that death occurred at 4 A. M. , from the causes and on the date stated above.			
23A. SIGNATURE Howard H. Warner		23B. ADDRESS 2404 Garrison Pl		23C. DATE SIGNED 3-29-59	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE March 31, 1959		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		25. FUNERAL DIRECTOR ADDRESS Henry W. Jenkins & Son Co. 4905 York Rd.			

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

ML CERTIFICATION

24A. BURIAL, CREMATION, REMOVAL (Specify)

DATE RECEIVED BY LOCAL REGISTRAR

MAR 31 1959

APR 2 1959

H. Jenkins & Son Co.

Funeral Director

ADDRESS

This form is to be completed by the physician or other person who has attended the deceased and is to be filed with the local health department. It is not to be used for the purpose of determining the cause of death. The information on this form is to be used for the purpose of determining the cause of death. The information on this form is to be used for the purpose of determining the cause of death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED MARRIAGE		2. SEX A. MALE B. FEMALE	
3. DATE OF DEATH A. DATE B. TIME		4. PLACE OF DEATH A. HOME B. HOSPITAL C. OTHER	
5. CITY OR TOWN IN WHICH DECEASED DIED		6. COUNTY	
7. STATE		8. ZIP CODE	
9. RACE A. WHITE B. NEGRO C. OTHER		10. AGE A. IN YEARS B. MONTHS C. DAYS	
11. OCCUPATION		12. EDUCATION	
13. MARITAL STATUS A. SINGLE B. MARRIED C. DIVORCED D. WIDOWED		14. DATE OF MARRIAGE	
15. NAME OF SPOUSE		16. DATE OF DEATH OF SPOUSE	
17. NAME OF NEXT OF KIN		18. ADDRESS OF NEXT OF KIN	
19. NAME OF PHYSICIAN		20. ADDRESS OF PHYSICIAN	
21. NAME OF HOSPITAL		22. ADDRESS OF HOSPITAL	
23. NAME OF CREMATOR		24. ADDRESS OF CREMATOR	
25. NAME OF BURIAL PLACE		26. ADDRESS OF BURIAL PLACE	
27. NAME OF FUNERAL HOME		28. ADDRESS OF FUNERAL HOME	
29. NAME OF CEMETERY		30. ADDRESS OF CEMETERY	
31. NAME OF INTERMENT		32. ADDRESS OF INTERMENT	
33. NAME OF BURIAL		34. ADDRESS OF BURIAL	
35. NAME OF CREMATION		36. ADDRESS OF CREMATION	
37. NAME OF OTHER		38. ADDRESS OF OTHER	
39. NAME OF OTHER		40. ADDRESS OF OTHER	
41. NAME OF OTHER		42. ADDRESS OF OTHER	
43. NAME OF OTHER		44. ADDRESS OF OTHER	
45. NAME OF OTHER		46. ADDRESS OF OTHER	
47. NAME OF OTHER		48. ADDRESS OF OTHER	
49. NAME OF OTHER		50. ADDRESS OF OTHER	
51. NAME OF OTHER		52. ADDRESS OF OTHER	
53. NAME OF OTHER		54. ADDRESS OF OTHER	
55. NAME OF OTHER		56. ADDRESS OF OTHER	
57. NAME OF OTHER		58. ADDRESS OF OTHER	
59. NAME OF OTHER		60. ADDRESS OF OTHER	
61. NAME OF OTHER		62. ADDRESS OF OTHER	
63. NAME OF OTHER		64. ADDRESS OF OTHER	
65. NAME OF OTHER		66. ADDRESS OF OTHER	
67. NAME OF OTHER		68. ADDRESS OF OTHER	
69. NAME OF OTHER		70. ADDRESS OF OTHER	
71. NAME OF OTHER		72. ADDRESS OF OTHER	
73. NAME OF OTHER		74. ADDRESS OF OTHER	
75. NAME OF OTHER		76. ADDRESS OF OTHER	
77. NAME OF OTHER		78. ADDRESS OF OTHER	
79. NAME OF OTHER		80. ADDRESS OF OTHER	
81. NAME OF OTHER		82. ADDRESS OF OTHER	
83. NAME OF OTHER		84. ADDRESS OF OTHER	
85. NAME OF OTHER		86. ADDRESS OF OTHER	
87. NAME OF OTHER		88. ADDRESS OF OTHER	
89. NAME OF OTHER		90. ADDRESS OF OTHER	
91. NAME OF OTHER		92. ADDRESS OF OTHER	
93. NAME OF OTHER		94. ADDRESS OF OTHER	
95. NAME OF OTHER		96. ADDRESS OF OTHER	
97. NAME OF OTHER		98. ADDRESS OF OTHER	
99. NAME OF OTHER		100. ADDRESS OF OTHER	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02767

2793

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. LENGTH OF STAY IN 1b X Perry Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 154 Forge Rd.		d. STREET ADDRESS 154 Forge Rd.	
3. NAME OF DECEASED (Type or print) First Preston Middle A. Last Hall		4. DATE OF DEATH Month March Day 3 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1908
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Md. Penitentiary	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Hall		14. MOTHER'S MAIDEN NAME Miranda Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-12-6633	
17. INFORMANT Mrs. Helen C. Hall		Address 154 Forge Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Glomerulonephritis of the Brain 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema of the Lung DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 wks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		20g. (County) (State)	
21. I certify that I attended the deceased from July 1, 1952 , to 3/15, 1959 , that I last saw the deceased alive on 3-5-59 , and that death occurred at 2:30 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Goed Ruzic M.D.		ADDRESS (Street, city or town, state) 1011 N Charles St	
PHYSICIAN'S NAME (Type) Frederic Ruzic M.D.		DATE SIGNED Dalton A. And	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 7, 1959	22c. NAME OF CEMETERY OR CREMATORY St. Joseph's	22d. LOCATION (City, town, or county) (State) Fullerton, Balto. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassaker Funeral Home		ADDRESS 7401 Belair Rd	24a. REC'D BY REGISTRAR MAR 6 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

02768

Reg. Dist. No.

2792

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8706 Loch Bend Drive</u>		d. STREET ADDRESS <u>8706 Loch Bend Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Mr. Leo Joseph Hebert, Sr.</u>		4. DATE OF DEATH <u>March 7th 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Hebert</u>		14. MOTHER'S MAIDEN NAME <u>Marie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Mrs. Florence Hebert</u>	
17. INFORMANT <u>8706 Loch Bend Dr.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>Multiple arthritis.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 14, 1953</u> , to <u>Mar 7, 1959</u> , that I last saw the deceased alive on <u>Jan 14, 1958</u> , and that death occurred at <u>5 a. m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr Lee K Fargo</u> M.D.		ADDRESS (Street, city or town, state) <u>8155 Loch Raven Blvd</u>	
PHYSICIAN'S NAME (Type) <u>LEE K FARGO</u>		DATE SIGNED <u>Towson - 4 - Mds</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>31 159</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2794

CERTIFICATE OF DEATH

02769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 36 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS J HENRY		4. DATE OF DEATH Month Day Year MARCH 16 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 2, 1899
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN	11. BIRTHPLACE (State or foreign country) CAMBRIDGE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HAMPTON HENRY	
14. MOTHER'S MAIDEN NAME OCTAVIA LECOMPTE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-1	
16. SOCIAL SECURITY NO. 214-07-7328		17. INFORMANT Address CLIN REC VET ADM HOSP FT HOWARD MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LIVER WITH METASTASIS 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from February 8, 1959 , to March 16, 1959 , and that death occurred at 8:30 p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Crawford		ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		DATE SIGNED 3/17/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-20-59	22c. NAME OF CEMETERY OR CREMATORY CHRIST CHURCH CEMETERY	22d. LOCATION (City, town, or county) (State) CAMBRIDGE, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE MAR 23 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. House			

LeCompte Funeral Home

High St Cambridge Md

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2795

CERTIFICATE OF DEATH

02770

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>				c. LENGTH OF STAY IN 1b <u>76 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				e. STREET ADDRESS <u>2345 Eutaw Place</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>M</u> Last <u>Henry</u>				4. DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/21/1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas Henry</u>				14. MOTHER'S MAIDEN NAME <u>Sylvia Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>			
17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>lymphatic Leukemia</u>							
204.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>anemia, secondary</u>							
DUE TO (c) <u>PULMONARY TUBERCULOSIS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>002X</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>1/13</u> , 19 <u>59</u> , to <u>3/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>59</u> , and that death occurred at <u>6:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Newcomer</u>				ADDRESS (Street, city or town, state) <u>Mt. Wilson, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>William Newcomer, M.D.</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-3-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. ALBURN</u>		22d. LOCATION (City, town, or county) <u>BALTO</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Adolphus Halstead</u>				ADDRESS <u>918 Howard Hill Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

CERTIFICATE OF DEATH

1906

MASSACHUSETTS
DEPARTMENT OF HEALTH
BIRTH RECORDS

MASSACHUSETTS
DEPARTMENT OF HEALTH
BIRTH RECORDS

Name of Deceased		Date of Birth	
Sex		Age at Death	
Cause of Death		Place of Death	
Occupation		Residence	
Marital Status		Date of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Date of Registration	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02771

2702

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b 53 Dundalk		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
3. NAME OF DECEASED (Type or print) Raymond W. Hepner Sr.		4. DATE OF DEATH Month March Day 27 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1906
9. AGE (in years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Self-Employed Tavern Owner	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Hepner		14. MOTHER'S MAIDEN NAME Madeline ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-07-3557	
17. INFORMANT Mrs. Bertha Hepner		Address 198 German Hill Rd.	
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) ASCVD Disease (c) ASCVD Disease DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. Davis M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 31, 59	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		22d. LOCATION (City, town, or county) (State) German Hill Rd Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 7922 Wise Ave. 22, Md.	
24a. REC'D BY REGISTRAR MAR 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2796

CERTIFICATE OF DEATH

02772

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Baltimore 7			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dogwood Road				d. STREET ADDRESS Dogwood Road			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS W. HICKEY				4. DATE OF DEATH Month Day Year March 25 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-14-1882	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Hickey				14. MOTHER'S MAIDEN NAME Laura Colson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-14-9507		17. INFORMANT Address Mrs. Elizabeth Hickey, Baltimore 7, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA-BLADDER - METASTASES. 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 8, 19 56 , to March 25, 19 59 , that I last saw the deceased alive on MARCH 25, 19 59 , and that death occurred at 3:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edwin L. Pierpont M.D.				ADDRESS (Street, city or town, state) 8204 LEBERTY Rd BALTO. 7, Md. DATE SIGNED 3/25/59			
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-28-59		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2797

CERTIFICATE OF DEATH

Reg. Dist. No.

02773

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle B Last HICKS		4. DATE OF DEATH Month Marche Day 29 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 2, 1888
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Government	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Henry V. Hicks		14. MOTHER'S MAIDEN NAME Ida Garrity	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Infarction left kidney due to miral thromboses			
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 27 , 19 59 , to March 29 , 19 59 , and that death occurred at 9:25 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED John W. Crawford M.D. 3/30/59			
ACTUAL SIGNATURE John W. Crawford			
PHYSICIAN'S NAME (Type) JOHN W CRAWFORD, M.D. VAH FT HOWARD, MD 3/30/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-59	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE MacNabb Funeral Home, Frederick & Wade Aves. Catonsville, Md		24a. REC'D BY REGISTRAR APR 2 1959	
24b. REGISTRAR'S SIGNATURE Charles S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2798

CERTIFICATE OF DEATH

02774

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 6</i>	c. LENGTH OF STAY IN 1b <i>25 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore 6</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3820 Joppa Road</i>		d. STREET ADDRESS <i>13820 Joppa Road</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>ELIZABETH</i> Middle <i>A. HINCHLIFFE</i> Last		4. DATE OF DEATH Month <i>March</i> Day <i>30</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 27, 1873</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>South Wales</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Mark Bateman</i>	
14. MOTHER'S MAIDEN NAME <i>Elizabeth Harris</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Charles G. Rule</i> Address <i>4835 Baltimore ave. Phila. Pa.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Advanced myocarditis & arterio sclerosis</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>?</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Carcinoma of uterus.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2/15</i> , 19 <i>59</i> , to <i>3/26</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>3/26</i> , 19 <i>59</i> , and that death occurred at <i>7:45 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>J. Willis Guyton</i>		M.D. <i>3961 Greenmount Ave.</i>	
PHYSICIAN'S NAME (Type) <i>J. Willis Guyton M.D.</i>		<i>Balto. 18, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>April 2, 1959</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hill Side</i>	22d. LOCATION (City, town, or county) (State) <i>Montgomery Co. Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Benny W. Jenkins & Sons Co. 4905 York Rd.</i>		24a. REC'D BY REGISTRAR DATE <i>APR 2 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Charles G. Rule</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

02775

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8104 Harford Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Mary M. Hindle</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17th</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 4, 1879</u>	9. AGE (In years last birthday) <u>79</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>? Henderson</u>			14. MOTHER'S MAIDEN NAME <u>Sarah</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Mary G. Geers,</u> Address <u>same</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C-V disease</u> DUE TO (c) <u>12 hrs.</u> <u>10 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1955</u> to <u>March 17 1959</u> , that I last saw the deceased alive on <u>March 17, 1959</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Grenzer</u> M.D.			ADDRESS (Street, city or town, state) <u>1520 East 33rd Street</u>			DATE SIGNED <u>3/17/59</u>	
PHYSICIAN'S NAME (Type) <u>W. H. GRENZER M.D. Baltimore, 18, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kunk</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1914

05775

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1. NAME OF DECEASED JAMES H. HARRISON		2. SEX Male		3. AGE 60	
4. DATE OF DEATH Jan 10 1914		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Coronary Artery Disease		9. OCCASION OF DEATH Sudden	
10. SIGNATURE OF PHYSICIAN J. H. Harrison		11. SIGNATURE OF WITNESSES J. H. Harrison		12. SIGNATURE OF DECEASED J. H. Harrison	
13. SIGNATURE OF REGISTRAR J. H. Harrison		14. SIGNATURE OF CLERK J. H. Harrison		15. SIGNATURE OF JURY J. H. Harrison	
16. SIGNATURE OF JURY J. H. Harrison		17. SIGNATURE OF JURY J. H. Harrison		18. SIGNATURE OF JURY J. H. Harrison	
19. SIGNATURE OF JURY J. H. Harrison		20. SIGNATURE OF JURY J. H. Harrison		21. SIGNATURE OF JURY J. H. Harrison	
22. SIGNATURE OF JURY J. H. Harrison		23. SIGNATURE OF JURY J. H. Harrison		24. SIGNATURE OF JURY J. H. Harrison	
25. SIGNATURE OF JURY J. H. Harrison		26. SIGNATURE OF JURY J. H. Harrison		27. SIGNATURE OF JURY J. H. Harrison	
28. SIGNATURE OF JURY J. H. Harrison		29. SIGNATURE OF JURY J. H. Harrison		30. SIGNATURE OF JURY J. H. Harrison	
31. SIGNATURE OF JURY J. H. Harrison		32. SIGNATURE OF JURY J. H. Harrison		33. SIGNATURE OF JURY J. H. Harrison	
34. SIGNATURE OF JURY J. H. Harrison		35. SIGNATURE OF JURY J. H. Harrison		36. SIGNATURE OF JURY J. H. Harrison	
37. SIGNATURE OF JURY J. H. Harrison		38. SIGNATURE OF JURY J. H. Harrison		39. SIGNATURE OF JURY J. H. Harrison	
40. SIGNATURE OF JURY J. H. Harrison		41. SIGNATURE OF JURY J. H. Harrison		42. SIGNATURE OF JURY J. H. Harrison	
43. SIGNATURE OF JURY J. H. Harrison		44. SIGNATURE OF JURY J. H. Harrison		45. SIGNATURE OF JURY J. H. Harrison	
46. SIGNATURE OF JURY J. H. Harrison		47. SIGNATURE OF JURY J. H. Harrison		48. SIGNATURE OF JURY J. H. Harrison	
49. SIGNATURE OF JURY J. H. Harrison		50. SIGNATURE OF JURY J. H. Harrison		51. SIGNATURE OF JURY J. H. Harrison	
52. SIGNATURE OF JURY J. H. Harrison		53. SIGNATURE OF JURY J. H. Harrison		54. SIGNATURE OF JURY J. H. Harrison	
55. SIGNATURE OF JURY J. H. Harrison		56. SIGNATURE OF JURY J. H. Harrison		57. SIGNATURE OF JURY J. H. Harrison	
58. SIGNATURE OF JURY J. H. Harrison		59. SIGNATURE OF JURY J. H. Harrison		60. SIGNATURE OF JURY J. H. Harrison	
61. SIGNATURE OF JURY J. H. Harrison		62. SIGNATURE OF JURY J. H. Harrison		63. SIGNATURE OF JURY J. H. Harrison	
64. SIGNATURE OF JURY J. H. Harrison		65. SIGNATURE OF JURY J. H. Harrison		66. SIGNATURE OF JURY J. H. Harrison	
67. SIGNATURE OF JURY J. H. Harrison		68. SIGNATURE OF JURY J. H. Harrison		69. SIGNATURE OF JURY J. H. Harrison	
70. SIGNATURE OF JURY J. H. Harrison		71. SIGNATURE OF JURY J. H. Harrison		72. SIGNATURE OF JURY J. H. Harrison	
73. SIGNATURE OF JURY J. H. Harrison		74. SIGNATURE OF JURY J. H. Harrison		75. SIGNATURE OF JURY J. H. Harrison	
76. SIGNATURE OF JURY J. H. Harrison		77. SIGNATURE OF JURY J. H. Harrison		78. SIGNATURE OF JURY J. H. Harrison	
79. SIGNATURE OF JURY J. H. Harrison		80. SIGNATURE OF JURY J. H. Harrison		81. SIGNATURE OF JURY J. H. Harrison	
82. SIGNATURE OF JURY J. H. Harrison		83. SIGNATURE OF JURY J. H. Harrison		84. SIGNATURE OF JURY J. H. Harrison	
85. SIGNATURE OF JURY J. H. Harrison		86. SIGNATURE OF JURY J. H. Harrison		87. SIGNATURE OF JURY J. H. Harrison	
88. SIGNATURE OF JURY J. H. Harrison		89. SIGNATURE OF JURY J. H. Harrison		90. SIGNATURE OF JURY J. H. Harrison	
91. SIGNATURE OF JURY J. H. Harrison		92. SIGNATURE OF JURY J. H. Harrison		93. SIGNATURE OF JURY J. H. Harrison	
94. SIGNATURE OF JURY J. H. Harrison		95. SIGNATURE OF JURY J. H. Harrison		96. SIGNATURE OF JURY J. H. Harrison	
97. SIGNATURE OF JURY J. H. Harrison		98. SIGNATURE OF JURY J. H. Harrison		99. SIGNATURE OF JURY J. H. Harrison	
100. SIGNATURE OF JURY J. H. Harrison		101. SIGNATURE OF JURY J. H. Harrison		102. SIGNATURE OF JURY J. H. Harrison	

RECEIVED JAN 10 1914

2800

CERTIFICATE OF DEATH

02776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Samuel</i> First <i>a.</i> Middle <i>Hinkle</i> Last		4. DATE OF DEATH <i>March 4, 1959</i> Month <i>March</i> Day <i>4</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 18, 1869</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Storekeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Hinkle</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Mildred Hinkle</i> Address <i>Baltimore Rd</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> <i>Cerebral Vascular Accident</i> DUE TO (b) <i>Arteriosclerosis</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.			INTERVAL BETWEEN ONSET AND DEATH <i>48 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <i>John E. Gessner</i> attended the deceased from <i>July 3/4, 1958</i> to <i>3/4, 1959</i> , that I last saw the deceased alive on <i>3/4, 1959</i> , and that death occurred at <i>12:28 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John E. Gessner</i>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>JOHN E. GESSNER</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Mar 4/59</i>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Philip Krueger</i> ADDRESS <i>2024</i>		24a. REC'D BY REGISTRAR <i>MAR 6 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08738

CERTIFICATE OF DEATH

3600

MASSACHUSETTS DEPARTMENT OF HEALTH - BULLOKE 10

DATE OF DEATH

AGE

PLACE OF BIRTH

DEATH PLACE

CAUSE OF DEATH

SEX

RACE

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DEATH PLACE

SEX

RACE

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DEATH PLACE

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RACE

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DEATH PLACE

SEX

RACE

EDUCATION

OCCUPATION

MASSACHUSETTS DEPARTMENT OF HEALTH - BULLOKE 10

MASSACHUSETTS DEPARTMENT OF HEALTH - BULLOKE 10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2801

CERTIFICATE OF DEATH

Reg. Dist. No.

02777

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 2½ hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 313 N. Robinson Street			
3. NAME OF DECEASED (Type or print) First ALBERT Middle E Last HOCKMAN				4. DATE OF DEATH Month March Day 18 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1900		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver-Salesman		10b. KIND OF BUSINESS OR INDUSTRY Bakery Co		11. BIRTHPLACE (State or foreign country) Batavia, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Unknown Hockman				14. MOTHER'S MAIDEN NAME Ellen (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 213-10-9842		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 420.0 DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 hours 4 yrs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Post Myocardial Infarction							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7:05PM March 18, 1959 to 9:35PM March 19, 1959 , and that death occurred at 9:35P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE John W. Crawford M.D.				DATE SIGNED 3/19/59			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.				FORT HOWARD, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 21, 1959		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A Moran Funeral Home				24a. REC'D BY REGISTRAR MAR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2501

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		65		M		W		1880		BALTIMORE		MD		U.S.A.	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
MARRIED		SINGLE		MARRIED		DIVORCED		WIDOWED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JAN 10 1940		BALTIMORE		MD		U.S.A.		JAN 10 1940		BALTIMORE		MD		U.S.A.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		POLITICAL PARTY		SOCIETY		FAMILY	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		DEMOCRAT		NONE		NONE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JAN 10 1940		BALTIMORE		MD		U.S.A.		JAN 10 1940		BALTIMORE		MD		U.S.A.	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		POLITICAL PARTY		SOCIETY		FAMILY	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		DEMOCRAT		NONE		NONE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G239 3-16-59 et

2802

CERTIFICATE OF DEATH

Reg. Dist. No.

02778

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn c. LENGTH OF STAY IN 1b 3 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn d. STREET ADDRESS 6409 Windsor Mill Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dora B. Hoffman		4. DATE OF DEATH March 8, 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/3/1873
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Christian Brunnett	
14. MOTHER'S MAIDEN NAME Catherine Repborn		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NO		17. INFORMANT Dorothy M. Chance Address 6305 Mt. Alto Rd. 7	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Flu & pneumonia 480 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/51 , 19___, to 3/1/59 , 19___, that I last saw the deceased alive on 3/7/59 , 19___, and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Milton Schlenker		M.D. 6410 Windsor Mill Rd	
PHYSICIAN'S NAME (Type) Milton Schlenker		Balto - 7 - md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/11/59	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Pikesville Md
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury ADDRESS 6411 Windsor Mill Rd.		24a. REC'D BY REGISTRAR MAR 12 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hous

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2803

CERTIFICATE OF DEATH

Reg. Dist. No.

02779

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5206 WILKENS AVE.</u>		d. STREET ADDRESS <u>5206 WILKENS AVE</u>	
3. NAME OF DECEASED (Type or print) <u>MARIE ELIZABETH HOFMEISTER</u>		4. DATE OF DEATH <u>MARCH 12, 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 15, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>AUGUST WERNER</u>		14. MOTHER'S MAIDEN NAME <u>CHRISTINE SELIG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>CHARLES W. HOFMEISTER</u>		Address <u>5206 WILKENS AVE. CATONSVILLE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>degenerative C.V. Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>2 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-30</u> , 19 <u>57</u> , to <u>3-12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-12</u> , 19 <u>59</u> , and that death occurred at <u>12:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James E. Howard</u>		DATE SIGNED <u>3-12</u>	
PHYSICIAN'S NAME (Type) <u>Patonsville</u>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/14/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LODOW PARK CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons, Catonsville 28, Md.</u>		24. REC'D BY REGISTRAR <u>MAR 16 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

1903

102770

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of birth: <u>Jan 15, 1858</u></p>	
<p>5. Place of birth: <u>Massachusetts</u></p>		<p>6. Date of death: <u>Dec 10, 1903</u></p>	
<p>7. Cause of death: <u>Heart disease</u></p>		<p>8. Duration of illness: <u>One week</u></p>	
<p>9. Name of physician: <u>Dr. J. W. Smith</u></p>		<p>10. Name of undertaker: <u>John Doe</u></p>	
<p>11. Name of funeral home: <u>John Doe</u></p>		<p>12. Name of cemetery: <u>Greenwood</u></p>	
<p>13. Name of registrar: <u>John Doe</u></p>		<p>14. Name of witness: <u>John Doe</u></p>	
<p>15. Name of witness: <u>John Doe</u></p>		<p>16. Name of witness: <u>John Doe</u></p>	
<p>17. Name of witness: <u>John Doe</u></p>		<p>18. Name of witness: <u>John Doe</u></p>	
<p>19. Name of witness: <u>John Doe</u></p>		<p>20. Name of witness: <u>John Doe</u></p>	
<p>21. Name of witness: <u>John Doe</u></p>		<p>22. Name of witness: <u>John Doe</u></p>	
<p>23. Name of witness: <u>John Doe</u></p>		<p>24. Name of witness: <u>John Doe</u></p>	
<p>25. Name of witness: <u>John Doe</u></p>		<p>26. Name of witness: <u>John Doe</u></p>	
<p>27. Name of witness: <u>John Doe</u></p>		<p>28. Name of witness: <u>John Doe</u></p>	
<p>29. Name of witness: <u>John Doe</u></p>		<p>30. Name of witness: <u>John Doe</u></p>	
<p>31. Name of witness: <u>John Doe</u></p>		<p>32. Name of witness: <u>John Doe</u></p>	
<p>33. Name of witness: <u>John Doe</u></p>		<p>34. Name of witness: <u>John Doe</u></p>	
<p>35. Name of witness: <u>John Doe</u></p>		<p>36. Name of witness: <u>John Doe</u></p>	
<p>37. Name of witness: <u>John Doe</u></p>		<p>38. Name of witness: <u>John Doe</u></p>	
<p>39. Name of witness: <u>John Doe</u></p>		<p>40. Name of witness: <u>John Doe</u></p>	
<p>41. Name of witness: <u>John Doe</u></p>		<p>42. Name of witness: <u>John Doe</u></p>	
<p>43. Name of witness: <u>John Doe</u></p>		<p>44. Name of witness: <u>John Doe</u></p>	
<p>45. Name of witness: <u>John Doe</u></p>		<p>46. Name of witness: <u>John Doe</u></p>	
<p>47. Name of witness: <u>John Doe</u></p>		<p>48. Name of witness: <u>John Doe</u></p>	
<p>49. Name of witness: <u>John Doe</u></p>		<p>50. Name of witness: <u>John Doe</u></p>	
<p>51. Name of witness: <u>John Doe</u></p>		<p>52. Name of witness: <u>John Doe</u></p>	
<p>53. Name of witness: <u>John Doe</u></p>		<p>54. Name of witness: <u>John Doe</u></p>	
<p>55. Name of witness: <u>John Doe</u></p>		<p>56. Name of witness: <u>John Doe</u></p>	
<p>57. Name of witness: <u>John Doe</u></p>		<p>58. Name of witness: <u>John Doe</u></p>	
<p>59. Name of witness: <u>John Doe</u></p>		<p>60. Name of witness: <u>John Doe</u></p>	
<p>61. Name of witness: <u>John Doe</u></p>		<p>62. Name of witness: <u>John Doe</u></p>	
<p>63. Name of witness: <u>John Doe</u></p>		<p>64. Name of witness: <u>John Doe</u></p>	
<p>65. Name of witness: <u>John Doe</u></p>		<p>66. Name of witness: <u>John Doe</u></p>	
<p>67. Name of witness: <u>John Doe</u></p>		<p>68. Name of witness: <u>John Doe</u></p>	
<p>69. Name of witness: <u>John Doe</u></p>		<p>70. Name of witness: <u>John Doe</u></p>	
<p>71. Name of witness: <u>John Doe</u></p>		<p>72. Name of witness: <u>John Doe</u></p>	
<p>73. Name of witness: <u>John Doe</u></p>		<p>74. Name of witness: <u>John Doe</u></p>	
<p>75. Name of witness: <u>John Doe</u></p>		<p>76. Name of witness: <u>John Doe</u></p>	
<p>77. Name of witness: <u>John Doe</u></p>		<p>78. Name of witness: <u>John Doe</u></p>	
<p>79. Name of witness: <u>John Doe</u></p>		<p>80. Name of witness: <u>John Doe</u></p>	
<p>81. Name of witness: <u>John Doe</u></p>		<p>82. Name of witness: <u>John Doe</u></p>	
<p>83. Name of witness: <u>John Doe</u></p>		<p>84. Name of witness: <u>John Doe</u></p>	
<p>85. Name of witness: <u>John Doe</u></p>		<p>86. Name of witness: <u>John Doe</u></p>	
<p>87. Name of witness: <u>John Doe</u></p>		<p>88. Name of witness: <u>John Doe</u></p>	
<p>89. Name of witness: <u>John Doe</u></p>		<p>90. Name of witness: <u>John Doe</u></p>	
<p>91. Name of witness: <u>John Doe</u></p>		<p>92. Name of witness: <u>John Doe</u></p>	
<p>93. Name of witness: <u>John Doe</u></p>		<p>94. Name of witness: <u>John Doe</u></p>	
<p>95. Name of witness: <u>John Doe</u></p>		<p>96. Name of witness: <u>John Doe</u></p>	
<p>97. Name of witness: <u>John Doe</u></p>		<p>98. Name of witness: <u>John Doe</u></p>	
<p>99. Name of witness: <u>John Doe</u></p>		<p>100. Name of witness: <u>John Doe</u></p>	

THE STATE DEPARTMENT OF HEALTH, BOSTON, MASS.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02780

Reg. Dist. No.

2804

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 412 Butler R d.				d. STREET ADDRESS 412 Butler Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Sadie Middle Elizabeth Last Hohl				4. DATE OF DEATH Month March Day 9 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1875	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 9 Days 9 Hours 19 Min.	IF UNDER 24 HRS. Months 9 Days 9 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lykens, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Helt				14. MOTHER'S MAIDEN NAME Sarah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. John Ziegler, 412 Butler Rd., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Angina Pectoris DUE TO (c) Arteriosclerosis C-V Disease							INTERVAL BETWEEN ONSET AND DEATH 10 min. 5 yrs. 7 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none				
20c. TIME OF INJURY Month, Day, Year Hour a. p. none 19 p. m.			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> none at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 5-28-52 , 19____, to 3-9-59 , 19____, that I last saw the deceased alive on 3-8-59 , 19____, and that death occurred at 4:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd., Reisterstown, Md. DATE SIGNED 3-11-59							
ACTUAL SIGNATURE D. D. Caples				M.D. 6 Hanover Rd., Reisterstown, Md.			
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.				Reisterstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 51277		22b. DATE THEREOF 3-12-59		22c. NAME OF CEMETERY OR CREMATORY WOODLAWN		22d. LOCATION (City, town, or county) (State) GWYNDAIR AVE	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE BACH 525 N. HURST ST.				24a. REC'D BY REGISTRAR MAR 13 '59		24b. REGISTRAR'S SIGNATURE Anthony J. [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,

page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02780

CERTIFICATE OF DEATH

2208

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
JAMES J. JONES		45		M		W		1910		NEW YORK		NEW YORK		NEW YORK		1955		NEW YORK		NEW YORK		NEW YORK	
MARRIED		YES		YES		YES		YES		YES		YES		YES		YES		YES		YES		YES	
EDUCATION		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL		HIGH SCHOOL	
OCCUPATION		FARMER		FARMER		FARMER		FARMER		FARMER		FARMER		FARMER		FARMER		FARMER		FARMER		FARMER	
CAUSE OF DEATH		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE		HEART DISEASE	
MANNER OF DEATH		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		NATURAL	
SIGNATURE OF PHYSICIAN		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	
SIGNATURE OF REGISTRAR		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	



MASSACHUSETTS DEPARTMENT OF HEALTH
BATTLE ONE - 18
02780

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2805

CERTIFICATE OF DEATH

Reg. Dist. No.

02781

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 ESSEX			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 Mace Avenue				d. STREET ADDRESS 204 Mace Avenue			
3. NAME OF DECEASED (Type or print) ELIZABETH M. HORMANN				4. DATE OF DEATH MARCH 8, 1959			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 13, 1883	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND.	
12. CITIZEN OF WHAT COUNTRY? US.A.							
13. FATHER'S NAME ADAM BOSZ				14. MOTHER'S MAIDEN NAME MARIE UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 215 03 3781		17. MARRIAGE ADDRESS MRS JOHN CIESIELSKI MRS JAMES OTES 204 MACE AVENUE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 1 hr. ? years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/21 , 19 59 , to 3/8 , 19 59 , that I last saw the deceased alive on 3/8 , 19 59 , and that death occurred at 8:30 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE J. PLATT				ADDRESS (Street, city or town, state) 434 Eastern Ave. Essex, Md.			
PHYSICIAN'S NAME (Type)				DATE SIGNED 3/9/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/12/59		22c. NAME OF CEMETERY OR CREMATORY OAK LAWN CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTO. MD.				24a. REC'D BY REGISTRAR MAR 10 59		24b. REGISTRAR'S SIGNATURE Arthur S. Hall	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2806
CERTIFICATE OF DEATH

02782

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rossville		c. LENGTH OF STAY IN 1b X Rossville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 305 Gum Spring Rd.		d. STREET ADDRESS Box 305 Gum Spring Rd.	
3. NAME OF DECEASED (Type or print) Christina M. Huppman		4. DATE OF DEATH Month March Day 28 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1901
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Tavern	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Winkler		14. MOTHER'S MAIDEN NAME Mary Winkler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT John F. Huppman		Address Box 305 Gum Spring Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Cervix DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 yr 2 yrs
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1 19 59 , to March 28 19 59 , that I last saw the deceased alive on March 28 , 19 59 , and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore Md DATE SIGNED 3/30/59 ACTUAL SIGNATURE G.M. Baumgardner M.D. PHYSICIAN'S NAME (Type) G.M. Baumgardner			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-1-1959	22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lessahn Funeral Home		24a. REC'D BY REGISTRAR APR 1 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kross

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02783

Reg. Dist. No.

2807

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 8 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Helpers Convent, 1001 W. Joppa Rd.				d. STREET ADDRESS 1001 W. Joppa Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sister Mary Ancilla (Hurley)		First Middle Last		4. DATE OF DEATH March 20, 1959		Month Day Year 19	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 21, 1878	
9. AGE (In years last birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		11. BIRTHPLACE (State or foreign country) Wellsburg, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Hurley		14. MOTHER'S MAIDEN NAME Mary McCarthy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Convent Records, 1001 W. Joppa Rd. Towson, Md.		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO (b) Miliary Tuberculosis DUE TO (c) 2 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1, 1950 to March 24, 1959 that I last saw the deceased alive on March 3, 1959 and that death occurred at 3:30 A.M. from the causes and on the date stated above		ADDRESS (Street, city or town, state) 7501 York Road		DATE SIGNED 3/21/59			
ACTUAL SIGNATURE Charles F. O'Donnell		PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell		7501 York Road, Towson, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/59		22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery		22d. LOCATION (City, town, or county) (State) 1001 W. Joppa Rd. Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. Vernon Lamm		ADDRESS 4611 Pk. Hgts. Balto. Md.		24a. REC'D BY REGISTRAR 23 MAR 1959		24b. REGISTRAR'S SIGNATURE Arthur J. Hume	

VS A15 (4)
15M 10/57

VS A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 18 Film 241 4-29-59 ams										
2808										
CERTIFICATE OF DEATH										
Reg. Dist. No. 02784										
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> <u>3603 Sollex Rd.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural: Towson</u>					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5312 Baltimore County, Md.</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eudowood Sanatorium</u> <u>Towson 4, Maryland</u>					4. STREET ADDRESS <u>3603 Sollex Rd.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>French</u> Middle <u>Wilbert</u> Last <u>Hylton</u>					4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1959</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-10-99</u>		9. AGE (In years last birthday) <u>59</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mine</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		IF UNDER 1 YEAR Months <u>59</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		
13. FATHER'S NAME <u>Peter Hylton</u>					14. MOTHER'S MAIDEN NAME <u>Ossie Aleff</u> OCCIE ALIFF					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>232-165791</u>		17. INFORMANT <u>Personal History</u> <u>Hospital Records, Eudowood Sanatorium</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Myocardial Infarction</u> DUE TO <u>SILICOTUBERCULOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 yrs</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Jan 11</u> , 19 <u>56</u> , to <u>Mar 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar 27</u> , 19 <u>59</u> , and that death occurred at <u>7:20 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Milton B. Kress</u> M.D. <u>Eudowood Sanatorium, Towson 4, Md.</u> PHYSICIAN'S NAME (Type) <u>Milton B. Kress, M.D.</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial</u>			22d. LOCATION (City, town, or county) _____ (State) <u>Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley, Inc.</u> ADDRESS <u>Dundalk 22, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>APR 1 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kress</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF DECEASED</p>		<p>12. SIGNATURE OF WITNESSES</p>	
<p>13. SIGNATURE OF MINISTER</p>		<p>14. SIGNATURE OF CLERK</p>	

I hereby certify that the foregoing is a true and correct copy of the original record of the death of the above named person, as the same appears in the records of the Department of Health, State of New York, for the year 1914.

J. J. L. [Signature]
 J. J. L. [Signature]
 J. J. L. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02785

2809

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 yrs 4m. 13	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE		d. STREET ADDRESS 1724 Guilford Ave	
3. NAME OF DECEASED (Type or print) First GRACE Middle Marie Last ISAACS		4. DATE OF DEATH 3 Month 11 Day 1959	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-2-1876
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-keeper		10b. KIND OF BUSINESS OR INDUSTRY Hotel work	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bradley Preston Isaacs		14. MOTHER'S MAIDEN NAME Mary B. Isaacs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Schaefer		Address 1724 Guilford Ave. Balto.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-11-1959 to 3-11-1959 , that I last saw the deceased alive on 3-11-59 , 1959, and that death occurred at 445 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hosp. DATE SIGNED 3-11-59			
ACTUAL SIGNATURE Aristides Simopoulos M.D.		PHYSICIAN'S NAME (Type) Aristides Simopoulos	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-14-59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS Baltimore	
24a. REC'D BY REGISTRAR MAR 13 '59		DATE MAR 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Frank		DATE	

02782

CERTIFICATE OF DEATH

22402

18

MAY 1964

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. RACE White		4. DATE OF BIRTH May 19, 1928		5. PLACE OF BIRTH Jackson, Tennessee	
6. DATE OF DEATH May 2, 1968		7. PLACE OF DEATH Memphis, Tennessee		8. CAUSE OF DEATH Felon's escape from prison		9. MANNER OF DEATH Homicide		10. MEDICAL EXAMINER Dr. J. H. Hume	
11. SIGNATURE OF DECEASED James Earl Ray		12. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		13. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		14. SIGNATURE OF CORONER Dr. J. H. Hume		15. SIGNATURE OF JURY James Earl Ray	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		18. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		19. SIGNATURE OF CORONER Dr. J. H. Hume		20. SIGNATURE OF JURY James Earl Ray	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		23. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		24. SIGNATURE OF CORONER Dr. J. H. Hume		25. SIGNATURE OF JURY James Earl Ray	
26. SIGNATURE OF DECEASED James Earl Ray		27. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		28. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		29. SIGNATURE OF CORONER Dr. J. H. Hume		30. SIGNATURE OF JURY James Earl Ray	
31. SIGNATURE OF DECEASED James Earl Ray		32. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		33. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		34. SIGNATURE OF CORONER Dr. J. H. Hume		35. SIGNATURE OF JURY James Earl Ray	
36. SIGNATURE OF DECEASED James Earl Ray		37. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		38. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		39. SIGNATURE OF CORONER Dr. J. H. Hume		40. SIGNATURE OF JURY James Earl Ray	
41. SIGNATURE OF DECEASED James Earl Ray		42. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		43. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		44. SIGNATURE OF CORONER Dr. J. H. Hume		45. SIGNATURE OF JURY James Earl Ray	
46. SIGNATURE OF DECEASED James Earl Ray		47. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		48. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		49. SIGNATURE OF CORONER Dr. J. H. Hume		50. SIGNATURE OF JURY James Earl Ray	
51. SIGNATURE OF DECEASED James Earl Ray		52. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		53. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		54. SIGNATURE OF CORONER Dr. J. H. Hume		55. SIGNATURE OF JURY James Earl Ray	
56. SIGNATURE OF DECEASED James Earl Ray		57. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		58. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		59. SIGNATURE OF CORONER Dr. J. H. Hume		60. SIGNATURE OF JURY James Earl Ray	
61. SIGNATURE OF DECEASED James Earl Ray		62. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		63. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		64. SIGNATURE OF CORONER Dr. J. H. Hume		65. SIGNATURE OF JURY James Earl Ray	
66. SIGNATURE OF DECEASED James Earl Ray		67. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		68. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		69. SIGNATURE OF CORONER Dr. J. H. Hume		70. SIGNATURE OF JURY James Earl Ray	
71. SIGNATURE OF DECEASED James Earl Ray		72. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		73. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		74. SIGNATURE OF CORONER Dr. J. H. Hume		75. SIGNATURE OF JURY James Earl Ray	
76. SIGNATURE OF DECEASED James Earl Ray		77. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		78. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		79. SIGNATURE OF CORONER Dr. J. H. Hume		80. SIGNATURE OF JURY James Earl Ray	
81. SIGNATURE OF DECEASED James Earl Ray		82. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		83. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		84. SIGNATURE OF CORONER Dr. J. H. Hume		85. SIGNATURE OF JURY James Earl Ray	
86. SIGNATURE OF DECEASED James Earl Ray		87. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		88. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		89. SIGNATURE OF CORONER Dr. J. H. Hume		90. SIGNATURE OF JURY James Earl Ray	
91. SIGNATURE OF DECEASED James Earl Ray		92. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		93. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		94. SIGNATURE OF CORONER Dr. J. H. Hume		95. SIGNATURE OF JURY James Earl Ray	
96. SIGNATURE OF DECEASED James Earl Ray		97. SIGNATURE OF NEXT OF KIN Mrs. Bernice Ray		98. SIGNATURE OF PHYSICIAN Dr. J. H. Hume		99. SIGNATURE OF CORONER Dr. J. H. Hume		100. SIGNATURE OF JURY James Earl Ray	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2810
CERTIFICATE OF DEATH

02786

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Ba/10</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>13a/10</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Woodlawn</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6507 Gilmore Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Raymond E. Jackson</u>				4. DATE OF DEATH Month Day Year <u>March 17 1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 21, 1916</u>	9. AGE (In years last birthday) <u>43 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Index</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stationary</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Mary R. Fox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-039886</u>		17. INFORMANT Address <u>Mrs. Catherine Jackson - 6507 Gilmore Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct.</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>3/16/59</u> , 19____, to <u>3/17/59</u> , 19____, that I last saw the deceased alive on <u>3/16/59</u> , 19____, and that death occurred at <u>8 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>Milton Schlenoff</u>		M.D. <u>6410 Windsor Mill Rd.</u>					
PHYSICIAN'S NAME (Type) <u>Milton Schlenoff MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 20/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) _____ (State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stansbury</u>				ADDRESS <u>6411 Windsor Mill Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES B. DAVIS		Male		45		Jan 15, 1865		Baltimore, Md.	
6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN	
Carpenter		Heart Disease		Home		10:30 AM		J. B. Smith, M.D.	
11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF CLERK		14. SIGNATURE OF JUDGE		15. SIGNATURE OF SHERIFF	
A. B. Jones		C. D. White, E. F. Green		G. H. Black		I. J. Brown		K. L. Grey	



THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS SIGNED BY THE APPROPRIATE OFFICIALS. IT IS ALSO THE DUTY OF THE REGISTRAR TO SEE THAT IT IS FILED IN THE APPROPRIATE PLACE AND THAT IT IS AVAILABLE FOR THE PUBLIC TO VIEW.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2717

CERTIFICATE OF DEATH

Reg. Dist. No. 02787

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lansdowne 51	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3109 Virginia Avenue		d. STREET ADDRESS 3109 Virginia Avenue #27	
3. NAME OF DECEASED (Type or print) JOHN GABRIEL JANUSKA		4. DATE OF DEATH Month March Day 23 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1877
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tailor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Yes	
17. INFORMANT Mr. Charles Januska-3109 Virginia Avenue #27		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis & old age DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , to 3.23.1959 , that I last saw the deceased alive on 3.23.1959 , and that death occurred at 1140 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1802 W. Balt St DATE SIGNED Balt 23 Md.			
ACTUAL SIGNATURE Stanley Ankudas M.D.		PHYSICIAN'S NAME (Type) STANLEY ANKUDAS	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/27/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE N.M. J. Tuckew		ADDRESS Balto 17, Md.	
24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE Charles L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02788

Reg. Dist. No.

2811

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b x Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7404 Belair Rd.		d. STREET ADDRESS 7404 Belair Rd.	
3. NAME OF DECEASED (Type or print) Bertha M. Jasper		4. DATE OF DEATH Month March Day 8 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1886
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Green		14. MOTHER'S MAIDEN NAME Mary Wurzbacher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-32-1631	
17. INFORMANT Charles A. Jasper		Address 4116 Taylor Ave. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extension of Pontine Angle Thrombosis - Cerebral 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pontine Angle Thrombosis - Cerebral DUE TO (c) Atherosclerotic Cardiovascular Disease Generalized PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction. Malnutrition. Endogenous & Anemia		INTERVAL BETWEEN ONSET AND DEATH 2-3 days approx 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-29 , 19 57 , to 3-8 , 19 59 , that I last saw the deceased alive on 3-7 , 19 59 , and that death occurred at 6:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John C. Hyle		ADDRESS (Street, city or town, state) 7527 Belair Rd Balto 6	
PHYSICIAN'S NAME (Type) JOHN C. Hyle		DATE SIGNED 3-9-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 11, 1959	
22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Luschn Funeral Home		ADDRESS 7404 Belair Rd.	
24a. REC'D BY REGISTRAR MAR 11 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Francis	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		1/1/1920		1/15/1965		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Usual hours of work		17. Usual mode of travel		18. Usual mode of transport		19. Usual mode of conveyance		20. Usual mode of conveyance	
Teacher		High School		Married		123 Main St		School		8:00 AM - 4:00 PM		Car		Car		Car		Car	
21. Usual mode of conveyance		22. Usual mode of conveyance		23. Usual mode of conveyance		24. Usual mode of conveyance		25. Usual mode of conveyance		26. Usual mode of conveyance		27. Usual mode of conveyance		28. Usual mode of conveyance		29. Usual mode of conveyance		30. Usual mode of conveyance	
Car		Car		Car		Car		Car		Car		Car		Car		Car		Car	
31. Usual mode of conveyance		32. Usual mode of conveyance		33. Usual mode of conveyance		34. Usual mode of conveyance		35. Usual mode of conveyance		36. Usual mode of conveyance		37. Usual mode of conveyance		38. Usual mode of conveyance		39. Usual mode of conveyance		40. Usual mode of conveyance	
Car		Car		Car		Car		Car		Car		Car		Car		Car		Car	
41. Usual mode of conveyance		42. Usual mode of conveyance		43. Usual mode of conveyance		44. Usual mode of conveyance		45. Usual mode of conveyance		46. Usual mode of conveyance		47. Usual mode of conveyance		48. Usual mode of conveyance		49. Usual mode of conveyance		50. Usual mode of conveyance	
Car		Car		Car		Car		Car		Car		Car		Car		Car		Car	
51. Usual mode of conveyance		52. Usual mode of conveyance		53. Usual mode of conveyance		54. Usual mode of conveyance		55. Usual mode of conveyance		56. Usual mode of conveyance		57. Usual mode of conveyance		58. Usual mode of conveyance		59. Usual mode of conveyance		60. Usual mode of conveyance	
Car		Car		Car		Car		Car		Car		Car		Car		Car		Car	
61. Usual mode of conveyance		62. Usual mode of conveyance		63. Usual mode of conveyance		64. Usual mode of conveyance		65. Usual mode of conveyance		66. Usual mode of conveyance		67. Usual mode of conveyance		68. Usual mode of conveyance		69. Usual mode of conveyance		70. Usual mode of conveyance	
Car		Car		Car		Car		Car		Car		Car		Car		Car		Car	
71. Usual mode of conveyance		72. Usual mode of conveyance		73. Usual mode of conveyance		74. Usual mode of conveyance		75. Usual mode of conveyance		76. Usual mode of conveyance		77. Usual mode of conveyance		78. Usual mode of conveyance		79. Usual mode of conveyance		80. Usual mode of conveyance	
Car		Car		Car		Car		Car		Car		Car		Car		Car		Car	
81. Usual mode of conveyance		82. Usual mode of conveyance		83. Usual mode of conveyance		84. Usual mode of conveyance		85. Usual mode of conveyance		86. Usual mode of conveyance		87. Usual mode of conveyance		88. Usual mode of conveyance		89. Usual mode of conveyance		90. Usual mode of conveyance	
Car		Car		Car		Car		Car		Car		Car		Car		Car		Car	
91. Usual mode of conveyance		92. Usual mode of conveyance		93. Usual mode of conveyance		94. Usual mode of conveyance		95. Usual mode of conveyance		96. Usual mode of conveyance		97. Usual mode of conveyance		98. Usual mode of conveyance		99. Usual mode of conveyance		100. Usual mode of conveyance	
Car		Car		Car		Car		Car		Car		Car		Car		Car		Car	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02789

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN TB X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7541 Belair Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie		4. DATE OF DEATH Month March Day 2 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry Hartman		14. MOTHER'S MAIDEN NAME Unknown Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Rocco Citro		Address 7541 Belair Rd. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Degeneration 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Failure and ^{acute} Advanced 2-3 Hypert. (c) Advanced Generalized Degenerative changes. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Endogenous Malnutrition and Generalized muscle wasting. INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY , 19 56 , to 2 Mar , 19 59 , that I last saw the deceased alive on 1 Mar , 19 58 , and that death occurred at 9 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John C. Hyle M.D. JOHN C. Hyle 7541 Belair Rd Balt 6 Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-2-1959	
22c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens		22d. LOCATION (City, town, or county) (State) Belair, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lewicki Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR MAR 6 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kiana	

CERTIFICATE OF DEATH

EXHIBIT BOND

Transferred from 100 Allen St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02790

Reg. Dist. No.

2703

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balts.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 53		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2363 Seaboard Rd. Balto. 22				d. STREET ADDRESS 2363 Seaboard Rd. 22			
3. NAME OF DECEASED (Type or print) First VOS Middle KAMPEAN Last 4. DATE OF DEATH Month MARCH Day 22 Year 1959							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-25-85	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10b. KIND OF BUSINESS OR INDUSTRY Beths. Steel		11. BIRTHPLACE (State or foreign country) Austria, Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Kampean				14. MOTHER'S MAIDEN NAME Unknown.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-07-4358		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. Davis M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-25-59		22c. NAME OF CEMETERY OR CREMATORY Balts. National		22d. LOCATION (City, town, or county) (State) Balts. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Connolly ADDRESS 4186 Eastern Blvd.				24a. REC'D BY REGISTRAR DATE MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2813

CERTIFICATE OF DEATH

Reg. Dist. No.

02791

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>25yr7mth25days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>3902 Edmondson Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>R.</u> Last <u>Kane</u>				4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 28, 1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John Starch</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Manger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 18, 1959</u> , to <u>March 10, 1959</u> , that I last saw the deceased alive on <u>March 10, 1959</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL</u> <u>3-10-59</u>					
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hubbard Furn. Home, 4107 Wilkens Ave.</u>				ADDRESS <u>Balto., Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2718

CERTIFICATE OF DEATH

Reg. Dist. No.

02797

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 5/ARBUTUS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1216 LEEDS TERRACE		d. STREET ADDRESS 1216 LEEDS TERRACE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last AUGUST KAZLAUSKI SR.		4. DATE OF DEATH Month Day Year 3/9/59 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 23, 1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Europe		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Matthew Kazlauski		14. MOTHER'S MAIDEN NAME Mary (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 212 01 8793	
17. INFORMANT Nellie Kazlauski		Address 1216 Leeds Terrace 27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis of the Rectum 154X DUE TO metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 8, 1959 , to March 9, 1959 , that I last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Coolahan		ADDRESS (Street, city or town, state) 4201 WILKENS AVE	
PHYSICIAN'S NAME (Type) BALTIMORE 29, MD		DATE SIGNED 3/13/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/13/59	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkens Ave	
24a. REC'D BY REGISTRAR DATE MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

02793

2719

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4410 Hooper Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Esther M. Keeney				4. DATE OF DEATH Month Day Year Mar. 11, 19 59			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1907		9. AGE (In years lost birthday) yrs. 51	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.				10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Philip Braoh				14. MOTHER'S MAIDEN NAME Alice White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Mr. Grafton Keeney, 4410 Hooper Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Bronchogenic Carcinoma 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 1 , 19 58 , to March 11 , 19 59 that I last saw the deceased alive on March 10 , 19 59 , and that death occurred at 9:00 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Nathan Racusin				ADDRESS (Street, city or town, state) 206 S. Gilmore St DATE SIGNED 3.11.59			
PHYSICIAN'S NAME (Type) NATHAN RACUSIN				ADDRESS 1391 to 23 Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/59		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.				24a. REC'D BY REGISTRAR DATE MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2719

Baltimore

MD.

Arduous

Arduous

4410 Hooper Ave

4410 Hooper Ave

John

George

Mar.

June 10, 1907

Y.

U.S.A.

MD.

C.M.

H.W.

Alice White

Philip Green

Mr. Green, 4410 Hooper Ave

Green, 4410 Hooper Ave

Philip Green

Philip Green

Philip Green, 4410 Hooper Ave

Philip Green, 4410 Hooper Ave

CERTIFICATE OF DEATH

Reg. Dist. No.

02794

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3421 Dunran Road		d. STREET ADDRESS 3421 Dunran Road	
3. NAME OF DECEASED (Type or print) First KENDRED ABEL Middle KELLUM Last		4. DATE OF DEATH Month March Day 14 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1901
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Kellum		14. MOTHER'S MAIDEN NAME Sadie Kirby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-01-1532	
17. INFORMANT Mrs. Amelia Kellum		Address 3421 Dunran Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of bladder 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic heart disease with failure			INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 1957 to March 1959 , that I last saw the deceased alive on 3-3 , 19 59 , and that death occurred at 4 p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wyman K Wong		M.D. 6801 Belair Rd ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Wyman K Wong		Balto. C. Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 18, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Meth. Ch. Cem.	22d. LOCATION (City, town, or county) (State) Fountain Green, Harford Co.
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC.		24a. REC'D BY REGISTRAR MAR 18 '59 DATE	
ADDRESS Baltimore, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-11-1932

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES DANIEL ROSS		AGE 34		SEX Male		RACE White		DATE OF DEATH July 21, 1932		PLACE OF DEATH JAMES DANIEL ROSS	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		LOCALITY OF DEATH Baltimore, Md.		CITY OF DEATH Baltimore		COUNTY OF DEATH Baltimore	
NAME OF DECEASED JAMES DANIEL ROSS		AGE 34		SEX Male		RACE White		DATE OF DEATH July 21, 1932		PLACE OF DEATH JAMES DANIEL ROSS	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		LOCALITY OF DEATH Baltimore, Md.		CITY OF DEATH Baltimore		COUNTY OF DEATH Baltimore	

NAME OF DECEASED JAMES DANIEL ROSS		AGE 34		SEX Male		RACE White		DATE OF DEATH July 21, 1932		PLACE OF DEATH JAMES DANIEL ROSS	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		LOCALITY OF DEATH Baltimore, Md.		CITY OF DEATH Baltimore		COUNTY OF DEATH Baltimore	
NAME OF DECEASED JAMES DANIEL ROSS		AGE 34		SEX Male		RACE White		DATE OF DEATH July 21, 1932		PLACE OF DEATH JAMES DANIEL ROSS	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease		DISEASE OR INJURY Coronary Artery Disease		LOCALITY OF DEATH Baltimore, Md.		CITY OF DEATH Baltimore		COUNTY OF DEATH Baltimore	

2814

CERTIFICATE OF DEATH

02795

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - GRANITE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - GRANITE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>OFFUTT RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>DUFF</u> Last <u>KEMP</u>				4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>19 59</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 6, 1888</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB KEMP</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-40-5978</u>		17. INFORMANT <u>MRS. Nettie C. KEMP</u> Address <u>OFFUTT RD GRANITE, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 CONGESTIVE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS.</u> DUE TO <u>CORONARY ARTERY DISEASE</u> (c) <u>EMPHYSEMA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u> <u>1 YEAR, 15 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 16, 19 57</u> to <u>MARCH 25, 19 59</u> , that I last saw the deceased alive on <u>MARCH 23, 19 59</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8204 L. BERTY RD</u> DATE SIGNED <u>3/25/59</u> ACTUAL SIGNATURE <u>Edwin Pierpont</u> M.D. <u>EDWIN L. PIERPONT, M.D. BALTO. 7, Md.</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/28/59</u>		<u>St. Michaels Church Cemetery</u>		<u>Poplar Springs Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u> ADDRESS <u>8728 Liberty Rd. Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

26

MD. 53-101

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of filing	
13. Name of informant		14. Relationship to deceased		15. Address of informant		16. Date of interview		17. Signature of informant		18. Signature of registrar		19. Date of filing		20. Cause of death		21. Manner of death		22. Signature of physician		23. Signature of registrar		24. Date of filing	
25. Name of informant		26. Relationship to deceased		27. Address of informant		28. Date of interview		29. Signature of informant		30. Signature of registrar		31. Date of filing		32. Cause of death		33. Manner of death		34. Signature of physician		35. Signature of registrar		36. Date of filing	
37. Name of informant		38. Relationship to deceased		39. Address of informant		40. Date of interview		41. Signature of informant		42. Signature of registrar		43. Date of filing		44. Cause of death		45. Manner of death		46. Signature of physician		47. Signature of registrar		48. Date of filing	
49. Name of informant		50. Relationship to deceased		51. Address of informant		52. Date of interview		53. Signature of informant		54. Signature of registrar		55. Date of filing		56. Cause of death		57. Manner of death		58. Signature of physician		59. Signature of registrar		60. Date of filing	
61. Name of informant		62. Relationship to deceased		63. Address of informant		64. Date of interview		65. Signature of informant		66. Signature of registrar		67. Date of filing		68. Cause of death		69. Manner of death		70. Signature of physician		71. Signature of registrar		72. Date of filing	
73. Name of informant		74. Relationship to deceased		75. Address of informant		76. Date of interview		77. Signature of informant		78. Signature of registrar		79. Date of filing		80. Cause of death		81. Manner of death		82. Signature of physician		83. Signature of registrar		84. Date of filing	
85. Name of informant		86. Relationship to deceased		87. Address of informant		88. Date of interview		89. Signature of informant		90. Signature of registrar		91. Date of filing		92. Cause of death		93. Manner of death		94. Signature of physician		95. Signature of registrar		96. Date of filing	
97. Name of informant		98. Relationship to deceased		99. Address of informant		100. Date of interview		101. Signature of informant		102. Signature of registrar		103. Date of filing		104. Cause of death		105. Manner of death		106. Signature of physician		107. Signature of registrar		108. Date of filing	



RECEIVED
BALTIMORE
MAY 10 1918
DEPARTMENT OF HEALTH

2815

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3525 Meadowside Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7 d. STREET ADDRESS 3525 Meadowside Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle A. Last KENNARD		4. DATE OF DEATH Month March Day 13 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 16, 1977
9. AGE (In years last birthday) 81		IF UNDER 1 YEAR Months 81	IF UNDER 24 HRS. Days 13 Hours 1959 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Altoona, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME J. Fred Bitzberger	
14. MOTHER'S MAIDEN NAME Elizabeth Emfield		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Jessie Frey-3525 Meadowside Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion DUE TO (b) Cardiovascular disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) advanced arteriosclerosis DUE TO (c) advanced arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH about 1 hr 6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 20 , 1959, to March 13 , 1959, that I last saw the deceased alive on March 11 , 1959, and that death occurred at 3 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul S. Smith		ADDRESS (Street, city or town, state) 4508 N Charles St	
PHYSICIAN'S NAME (Type) Walter D. Smith		DATE SIGNED March 17 '59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/16/1959	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Woodlawn Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		24a. REC'D BY REGISTRAR DATE MAR 17 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Francis

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2816

CERTIFICATE OF DEATH

02797

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>		c. LENGTH OF STAY IN TB <u>4 YEARS-7 MO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MASONIC HOME</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
3. NAME OF DECEASED (Type or print) First <u>OLIVER</u> Middle <u>THOMAS</u> Last <u>KENNEY</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRODUCE BUSINESS</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>OLIVER J. KENNEY</u>		14. MOTHER'S MAIDEN NAME <u>KATE HESS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Frank L. Smith Jr.</u>		Address <u>Cockeysville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardio</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vascular Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>9-26</u> , 19 <u>58</u> , to <u>3-25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-25</u> , 19 <u>59</u> , and that death occurred at <u>8:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur L. Hess</u>		ADDRESS (Street, city or town, state) <u>Cockeysville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Arthur L. Hess</u>		DATE SIGNED <u>3/25/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-28-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hess</u>			

2817

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 98 Smithwood Ave., Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 Old Court Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Summitt Nursing Home				d. STREET ADDRESS Catonsville, Balto. Co.			
3. NAME OF DECEASED (Type or print) First HUGH Middle F. Last KERR				4. DATE OF DEATH Month 3 Day 13 Year 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) 86 (Y)		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Clerk				10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Scotland	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no -				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs. Constance F. Kerr-7309 York Rd.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Mar 59 , to 13 Mar 59 , that I last saw the deceased alive on 12 Mar 59 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. E. McGreth				ADDRESS (Street, city or town, state) DATE SIGNED 1303 Frederick Rd Catonsville 28md 3/13/59			
PHYSICIAN'S NAME (Type) W. E. McGreth							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 3/14/59		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cem.		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE WIEDEFELD & SON				24a. REC'D BY REGISTRAR MAR 16 59			
ADDRESS 501 E. 22nd St.				24b. REGISTRAR'S SIGNATURE Arthur L. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02799
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY DELAWARE Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 205 Detroit Ave.				d. STREET ADDRESS 205 Detroit Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last OSBIE ERVIN KIRK				4. DATE OF DEATH Month Day Year March 29, 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 16, 1887	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor				10b. KIND OF BUSINESS OR INDUSTRY Signal Corps.		11. BIRTHPLACE (State or foreign country) Tennessee	
13. FATHER'S NAME William Kirk				14. MOTHER'S MAIDEN NAME Victoria Whitwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Lula Kirk 205 Detroit Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary atherosclerosis</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u> EXAMINER'S NAME (Type) JACK C Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Medaow Ridge Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.				22d. LOCATION (City, town, or county) (State) Dorsey, Md.		24a. REC'D BY REGISTRAR DATE MAR 31 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

02100

STATE OF MINNESOTA
DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF EXAMINER		10. SIGNATURE OF ATTENDING PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF JURY	

2818

CERTIFICATE OF DEATH

02800

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XSPARROWS POINT</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>812 E. STREET</u>				d. STREET ADDRESS <u>1812 E. STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle Last <u>EMMA W. KIRSHNER</u>		4. DATE OF DEATH		Month Day Year <u>MARCH 25 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 8. 1875</u>		9. AGE (In years lost birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM WILD</u>				14. MOTHER'S MAIDEN NAME <u>DONT KNOW</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>JOHN W. REID</u>		Address <u>812 E. ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic H.D.</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>plus.</u> <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>MAY 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>MAR 25</u> , 19 <u>59</u> , and that death occurred at <u>9 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James T. Means</u>		M.D.		ADDRESS (Street, city or town, state) <u>520 DST. BALTIMORE MD</u>		DATE SIGNED <u>3/25/59</u>	
PHYSICIAN'S NAME (Type) <u>James T. Means</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>3/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEM</u>		22d. LOCATION (City, town, or county) (State) <u>ROANOKE VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME 2112 DUNDALK</u>				24a. REC'D BY REGISTRAR <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hand</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2819

CERTIFICATE OF DEATH

Reg. Dist. No.

02801

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN 1b <u>54 ESSEX</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>431 LORRAINE AVE. (21)</u>		d. STREET ADDRESS <u>1421 LORRAINE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>DUNCAN</u> Last <u>KNIGHT</u>		4. DATE OF DEATH Month <u>MAR</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-1879</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Con. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ODEN KNIGHT</u>		14. MOTHER'S MAIDEN NAME <u>ELLA DUNCAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Circulatory Collapse</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart failure, chronic</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>more than 4 years</u> <u>several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes melitus, - Cerebral hemorrhage.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>
20f. (City or town) <u>—</u>		(County) <u>—</u> (State) <u>—</u>
21. I certify that I attended the deceased from <u>June 2, 1955</u> to <u>March 26, 1959</u> , that I last saw the deceased alive on <u>March 26, 1959</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Eugene C. Baumann</u> M.D.		DATE SIGNED <u>March 21st 1959</u>
PHYSICIAN'S NAME (Type) <u>Eugene C. Baumann</u>		ADDRESS (Street, city or town, state) <u>413 Eastern Ave. Essex 21nd 3rd 19</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-30-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>
22d. LOCATION (City, town, or county) <u>BALTO. CO. MD</u>		(State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		ADDRESS <u>418 Eastern Blvd. 21</u>
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2720

CERTIFICATE OF DEATH

02802

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST DENNIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST DENNIS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1849 SUTTON AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PEARL A KNIGHT First Middle Last		4. DATE OF DEATH MAR. 5, 1959 Month Day Year	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 17, 1893
9. AGE (In years, birth day) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME HARRY SELBY		14. MOTHER'S MAIDEN NAME ANNIE LEARS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NONE		17. INFORMANT JOHN J KNIGHT 76 S MORLEY ST. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Cardiovascular Disease (c) INTERVAL BETWEEN ONSET AND DEATH 10 min. 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-20 , 19 57 , to 3-9 , 19 59 , that I last saw the deceased alive on 12-24 , 19 58 , and that death occurred at 7:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Schaefer		ADDRESS (Street, city or town, state) 401 RANDOM ROAD BAL To. 29 MD.	
PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER		DATE SIGNED 3/6/59	
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL	22b. DATE THEREOF MAR. 9, 1959	22c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL	22d. LOCATION (City, town, or county) (State) BALTIMORE
23. FUNERAL DIRECTOR'S SIGNATURE HOWARD H HUBBARD		ADDRESS 4107 WILKENS AVE.	
24a. REC'D BY REGISTRAR MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100000

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

1950

NAME OF DECEASED HARRY J. HARRIS		DATE OF DEATH JAN 25 1950	
AGE 45		SEX M	
RACE WHITE		RELIGION METHODIST	
MARRIED YES		EDUCATION HIGH SCHOOL	
OCCUPATION LABORER		PLACE OF BIRTH MASSACHUSETTS	
US BIRTH YES		ALIEN REGISTRATION NO	
MILITARY SERVICE NO		REASON FOR DEATH HEART DISEASE	
IMMEDIATE CAUSE CORONARY THROMBOSIS		INTERVENING CAUSES HYPERTENSION	
PERMANENT CAUSE CORONARY ARTERY DISEASE		MANNER OF DEATH NATURAL	
PLACE OF DEATH HOME		ATTENDING PHYSICIAN DR. J. H. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED	
SIGNATURE OF WITNESSES		SIGNATURE OF REGISTRAR	

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02803

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Lane		e. STREET ADDRESS 311 Main Street	f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Lydia Elizabeth Knighting	4. DATE OF DEATH Month March Day 21 Year 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1879
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Syria, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Southard		14. MOTHER'S MAIDEN NAME Angeline Hurt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Henry Talbert, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 420.1 DUE TO causing the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 20 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State) none
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		DATE SIGNED 3-23-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 25/59	22c. NAME OF CEMETERY OR CREMATORY Reisterstown Methodist	22d. LOCATION (City, town, or county) (State) Reisterstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24. REGISTRAR'S SIGNATURE Arthur S. Thomas	

24a. REC'D BY REGISTRAR
DATE **MAR 26 '59**

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02804

Reg. Dist. No.

2821

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swings Mills</u>		c. LENGTH OF STAY IN 1b <u>3 yrs 9 mos</u> x <u>Randallstown</u> <u>Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Reservoir State Training</u>		d. STREET ADDRESS <u>Marriottville Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>E D N A</u> First <u>ALBERTA</u> Middle <u>KNOPE</u> Last		4. DATE OF DEATH Month <u>Mar</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-27-'31</u>
9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Knopf</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bowers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Reservoir Records - Swings Mills</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia due to aspirated food</u> <u>325.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>none</u> (c), stating the underlying cause last. (c) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital cerebral defect</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>6:12</u> a.m. <u>Mar</u> 1959 p.m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/4/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>
22d. LOCATION (City, town, or county) <u>WOODLAWN</u>		(State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEORGE L. Schwab</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 4 '59</u>	
ADDRESS <u>Babara A. Schwab 210, Rudwick Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2822

CERTIFICATE OF DEATH

Reg. Dist. No.

02806

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 9 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE, nr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 4304 Leeds Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First Middle Last AUGUST KRIEG		4. DATE OF DEATH Month March Day 20 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 2, 1883		9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY Chemical Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Krieg			14. MOTHER'S MAIDEN NAME Louisa Wolman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 213-01-9507		17. INFORMANT Clin Records, Vet. Administration Hosp. Ft. Howard			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 MONTH UNKNOWN							Md.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ATRIAL FIBRILLATION. PNEUMONIA							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 11, 19 59 , to March 20, 19 59 , and that death occurred at 10:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, Fort Howard, Maryland 3/20/59							
ACTUAL SIGNATURE John W. Crawford		M.D. VAH, Fort Howard, Maryland					
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M. D.		VAH, Fort Howard, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard Funeral Home, 4107 Wilkins Ave.				ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR MAR 23 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G240 3-24-59 et
2721 CERTIFICATE OF DEATH

Reg. Dist. No.

02807

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN 1b <u>4 MONTHS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1208 GREYSTONE RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>M.</u> Last <u>KROHN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/1879</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDIANA</u>	
11. BIRTHPLACE (State or foreign country) <u>INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard Eirich</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Nicol</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1208 GREYSTONE RD.</u>	
17. INFORMANT <u>MRS. GERARD J. COOGAN</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO <u>Hypertensive R. V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Serulicity</u> (c) <u>Serulicity</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Serulicity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (After nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 17, 1958</u> to <u>Mar 17, 1959</u> that I last saw the deceased alive on <u>Mar 17, 1959</u> , and that death occurred at <u>6 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul B. Beyer</u> M.D.		ADDRESS (Street, city or town, state) <u>3033 W. North Ave</u> DATE SIGNED <u>Apr 16 1959</u>	
PHYSICIAN'S NAME (Type) <u>M Paul Beyer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Truman Schwal</u> ADDRESS <u>3512 Frederick Ave. (29)</u>		24a. REC'D BY REGISTRAR <u>MAR 19 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

2823

CERTIFICATE OF DEATH

02808

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 25yr8mth28dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 1049 West Saratoga Street			
3. NAME OF DECEASED (Type or print) First Morris Middle Last Landy				4. DATE OF DEATH Month 3 Day 1 Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1892	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tailor		10b. KIND OF BUSINESS OR INDUSTRY tailoring		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia	
13. FATHER'S NAME Joseph Landy				14. MOTHER'S MAIDEN NAME Esther Leihman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE DUE TO ARTERIOSCLEROSIS GENERALIZED, EVER Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) ARTERIOSCLEROSIS GENERALIZED, EVER DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 27 , 19 58 , to March 1 , 19 59 , that I last saw the deceased alive on March 1 , 19 59 , and that death occurred at 10 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bruno Radauskas M.D.				ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL		DATE SIGNED 3/1/1959	
PHYSICIAN'S NAME (Type) BRUNO RADAUSKAS				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial 3-2-59		3-2-59		Rosedale		Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Jr 2100 Canton Pl				24a. REC'D BY REGISTRAR DATE MAR 3 59		24b. REGISTRAR'S SIGNATURE Cuthbert L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02809

2824

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 66 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) BALTIMORE d. STREET ADDRESS 6032 CARTER AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last EFFIN L. LEHUKEY		4. DATE OF DEATH Month Day Year MARCH 23 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 16, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		10b. KIND OF BUSINESS OR INDUSTRY CROWN CORK & SEAL	9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS LEHUKEY		14. MOTHER'S MAIDEN NAME MARY CHORPALIK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 220-22-1403	
17. INFORMANT CLIN. REC. VET. AIM. HOSP. FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LIVER 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS +			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from January 16, 19 59 , to March 23, 19 59 , and that death occurred at 12:55 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED VAH, Fort Howard, Maryland 3/23/59 ACTUAL SIGNATURE John W. Crawford M.D. PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M. D. VAH, Fort Howard, Maryland 3/23/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-59	
22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Buck Funeral Home, 5305 Harford Road		24a. REC'D BY REGISTRAR MAR 26 '59	
ADDRESS Baltimore, Md.		24b. REGISTRAR'S SIGNATURE Arthur E. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-203

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

DATE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2825 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02810**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore Co			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point				c. LENGTH OF STAY IN 1b Rural (Dundalk) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrows Point Hospital				d. STREET ADDRESS 6833 Holabird Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Lewandowski				4. DATE OF DEATH Month Day Year March 28 19 59			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/1/1897	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Crane Operator	
10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Philadelphia Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-09-4376		17. INFORMANT Address Laura Lewandowski 6833 Holabird Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M.B. Davis				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) M.B. Davis MD				DATE SIGNED 3/28			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/59		22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Weber & Sons Inc 401 S. Chester				24a. REC'D BY REGISTRAR MAR 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar per 18a to burial, cremation, or removal.

DEATH CERTIFICATE

10-210

NAME OF DECEASED

DATE OF DEATH

AGE OF DECEASED

PLACE OF DEATH

SEX

CAUSE OF DEATH

DATE

TIME

BY

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

DATE

TIME

PLACE OF DEATH

DATE

TIME

BY

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

DATE

TIME

BY

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

DATE

TIME

BY

John A. Baker & Son, Inc. Boston

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2826

CERTIFICATE OF DEATH

Reg. Dist. No.

02811

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4220 Darnell Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Minnie Middle Elsie Last Lewis				4. DATE OF DEATH Month March Day 7 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 28, 1886	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Frank W. Hoffman				14. MOTHER'S MAIDEN NAME Elizabeth C. Yocum			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Frank M. Dunkes Address 4220 Darnell Road, Baltimore 6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular-Renal Disease DUE TO (c) Arteriosclerosis-Generalized							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia - right							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Md.	
21. I certify that I attended the deceased from November, 1958 , to March 7, 1959 , that I last saw the deceased alive on March 6, 1958 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel B. Wolfe				ADDRESS (Street, city or town, state) 1331 E. North Ave Baltimore 13, Md.			
DATE SIGNED March 9 '59							
PHYSICIAN'S NAME (Type) SAMUEL B. WOLFE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial		22b. DATE THEREOF March 9, 1959		22c. NAME OF CEMETERY OR CREMATORY Pottstown (West end) Pottstown, Pennsylvania		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home				24a. REC'D BY REGISTRAR March 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	
ADDRESS 3631 Falls Road Baltimore 11							

255

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 17 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2802 W. Woodwell Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
f. STREET ADDRESS 2802 W. Woodwell Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ESTELLA Middle MHHALA Last LIDDLE		4. DATE OF DEATH Month March Day 16 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-26-1914
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Drapery Indust.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph R. Lineberry		14. MOTHER'S MAIDEN NAME Hannah E. Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 231-16-2767	
17. INFORMANT Joseph A. Liddle		Address (Same)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanosarcoma 190.5 DUE TO Primary on skin of back with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 16 Mos			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 1957 , to Mar. 1959 , that I last saw the deceased alive on March 16, 1959 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11 E. Chase St. Balt (2) DATE SIGNED 3-16-59			
ACTUAL SIGNATURE Karl F. Mech, M.D.		PHYSICIAN'S NAME (Type) Karl F. Mech, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/20/59	22c. NAME OF CEMETERY OR CREMATORY Gladeville Methodist	22d. LOCATION (City, town, or county) (State) Galax, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley		24a. REC'D BY REGISTRAR MAR 19 59	24b. REGISTRAR'S SIGNATURE Arthur S. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED Joseph H. Lathrop</p>		<p>2. SEX Male</p>		<p>3. AGE 19 yrs</p>	
<p>4. DATE OF DEATH 1-26-1911</p>		<p>5. PLACE OF DEATH Woodward, Kansas</p>		<p>6. PLACE OF BIRTH Woodward, Kansas</p>	
<p>7. OCCUPATION Student</p>		<p>8. CAUSE OF DEATH Primary of skin of back with Generalized Acetabular</p>		<p>9. MANNER OF DEATH Accidental</p>	
<p>10. SIGNATURE OF PHYSICIAN Dr. J. H. Lathrop</p>		<p>11. SIGNATURE OF WITNESSES Dr. J. H. Lathrop</p>		<p>12. SIGNATURE OF DECEASED Joseph H. Lathrop</p>	
<p>13. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>14. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>15. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>16. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>17. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>18. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>19. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>20. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>21. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>22. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>23. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>24. NAME OF FUNERAL HOME Woodward, Kansas</p>	
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<p>31. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>32. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>33. NAME OF FUNERAL HOME Woodward, Kansas</p>	
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<p>49. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>50. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>51. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>52. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>53. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>54. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>55. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>56. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>57. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>58. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>59. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>60. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>61. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>62. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>63. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>64. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>65. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>66. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>67. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>68. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>69. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>70. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>71. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>72. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>73. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>74. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>75. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>76. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>77. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>78. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>79. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>80. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>81. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>82. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>83. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>84. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>85. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>86. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>87. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>88. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>89. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>90. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>91. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>92. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>93. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>94. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>95. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>96. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>97. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>98. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>99. NAME OF FUNERAL HOME Woodward, Kansas</p>	
<p>100. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>101. NAME OF FUNERAL HOME Woodward, Kansas</p>		<p>102. NAME OF FUNERAL HOME Woodward, Kansas</p>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

2827

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FEDERALSBURG 05X-2	
c. LENGTH OF STAY IN b 5 MONTHS		d. STREET ADDRESS 312 CHARLES ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle LIMORE Last LIMORE		4. DATE OF DEATH Month 3 Day 26 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/1879
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY DELAWARE	
11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JOHN LIMORE		14. MOTHER'S MAIDEN NAME MARGARET THOMAS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-14-8892	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL THROMBOSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/17 , 19 58 , to 3/26 , 19 59 , that I last saw the deceased alive on 3/26 , 19 59 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W Newcomer		ADDRESS (Street, city or town, state) Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		DATE SIGNED Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 29, 1959	
22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ed Hampton Son, Federalsburg		ADDRESS md	
24a. REC'D BY REGISTRAR DATE MAR 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAILED 2: THE DEPARTMENT OF HEALTH-BALTIMORE 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2722

CERTIFICATE OF DEATH

02814

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1204 Maiden Choice Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Ella Lotz		4. DATE OF DEATH March 16, 1959	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1871
9. AGE (In years last birthday) 87		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Samuel Winks		14. MOTHER'S MAIDEN NAME Marian Cleary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Clara E. Lotz		Address 1204 Maiden Choice Lane	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary Artery Disease DUE TO (c) Dilated Cardiomyopathy		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-14 , 19 50 , to 3-16 , 19 59 , that I last saw the deceased alive on 3-14 , 19 59 , and that death occurred at 10 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. Unbeck Jr		M.D. 1227 W. Union Blvd	
PHYSICIAN'S NAME (Type) John		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/59	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John P. Unbeck Jr		ADDRESS 4107 Wilken Ave	
24a. RECEIVED BY REGISTRAR Mar 19 59		24b. REGISTRAR'S SIGNATURE Charles S. Kuntz	

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**FOR STATE
HEALTH DEPT.**

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **02815**

2828

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Essex (21)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 213"B" Golupski Rd.		d. STREET ADDRESS Box 213"B" Golupski Rd.	
3. NAME OF DECEASED (Type or print) Henry Joseph Luhrman		4. DATE OF DEATH March 6, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1899
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist		10b. KIND OF BUSINESS OR INDUSTRY Commmerical	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred Luhrman	
14. MOTHER'S MAIDEN NAME Elizabeth Delss		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WWI	
16. SOCIAL SECURITY NO. 217-03-1375		17. INFORMANT David Luhrman Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) EXTENSIVE Cancer of Both Lungs - Prob. H. Lox in origin 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) Lungs - Prob. H. Lox in origin (c) 1 DUE TO cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. Davis M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/9/59	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Bruzdziński		24a. REC'D BY REGISTRAR DATE MAR 11 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2708 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02816**

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TURNERS STATION		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TURNERS STATION (22)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 107 Center Ave. (22)				d. STREET ADDRESS 107 Center Ave. (22)			
3. NAME OF DECEASED (Type or print) First JOHN Middle LUPSE Last				4. DATE OF DEATH Month MARCH Day 9 Year 19 59			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH FEB. 10-1887		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL WORKER		10b. KIND OF BUSINESS OR INDUSTRY BETH. STEEL		11. BIRTHPLACE (State or foreign country) ROUMANIA			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Lupse			
14. MOTHER'S MAIDEN NAME 				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 213-07-7614		17. INFORMANT Address MRS. H. LUPSE 107 Center Ave (22)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bi-LATERAL PULMONARY TBC DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH 11 yrs							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE M. B. Davis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/10/59			
EXAMINER'S NAME (Type) M. B. Davis M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR. 12, 1959		22c. NAME OF CEMETERY OR CREMATORY SACRED HEART			
22d. LOCATION (City, town, or county) BALTO. CO. MD.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE John S. Connolly		ADDRESS 418 Eastern Blvd.		24a. REC'D BY REGISTRAR MAR 13 '59			
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar pending a burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2709

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02817

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TURNERS STATION	c. LENGTH OF STAY IN 1b 10 YRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TURNERS STATION	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 727 N. AVONDALE RD		d. STREET ADDRESS 727 N. AVONDALE RD	
3. NAME OF DECEASED (Type or print) F. LLANORA First LYNCH Middle Last		4. DATE OF DEATH Month 3 Day 12 Year 1959	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 79 yrs.
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME STEVEN CAINE		14. MOTHER'S MAIDEN NAME LOTTIE SPENCER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. LOTTIE JOHNSON 727 N. AVONDALE RD	
17. INFORMANT LOTTIE JOHNSON 727 N. AVONDALE RD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-Disease 422.1 DUE TO (b) Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/16/59	
22c. NAME OF CEMETERY OR CREMATORY Mt AUBURN		22d. LOCATION (City, town, or county) (State) BALTO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Hayn		ADDRESS 638 N. Gilmore St	
24a. REC'D BY REGISTRAR MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02818

2829

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 46 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First McDOWELL Middle ----- Last LYON				4. DATE OF DEATH Month March Day 3 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 14, 1895		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist			10b. KIND OF BUSINESS OR INDUSTRY Painter ans Writer		11. BIRTHPLACE (State or foreign country) Bristol, Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James P. Lyon				14. MOTHER'S MAIDEN NAME Elizabeth McDowell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 212-12-2378		17. INFORMANT Address Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASCITES AND HYDROTHORAX, BILATERAL							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 16, 19 59 , to March 3, 19 59 , and that death occurred at 2:10 A.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Chien Wei Lan ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 3/3/59 PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-6-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.				24a. REC'D BY REGISTRAR MAR 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2829

AMBI BOND

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to the quality of the scan.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2830

CERTIFICATE OF DEATH

02819

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase (20)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Chase (20)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Ave. Chase, Md.		d. STREET ADDRESS Eastern Ave. Chase, Md.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Edward Last Maddox		4. DATE OF DEATH Month March Day 30 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1873
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Maddox		14. MOTHER'S MAIDEN NAME Frances Hughes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 212-12-1038	
17. INFORMANT Margaret Ann Maddox		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic carcinoma of esophagus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 days 6 mos.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 19 59 to 3/30 1959 , that I last saw the deceased alive on 3/29 19 59 , and that death occurred at 9:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 434 Eastern Ave. Essex, Md. DATE SIGNED 3/31/59			
ACTUAL SIGNATURE J. Platt M.D.			
PHYSICIAN'S NAME (Type) J. PLATT, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-59	
22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Bruzdinski James Bruzdinski 1407 Eastern Ave.		24a. REC'D BY REGISTRAR DATE APR 6 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02820

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

Item 18 Film 241 4-14-59 ams

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3518 Rhom Road		d. STREET ADDRESS 3518 Rhom Road	
3. NAME OF DECEASED (Type or print) First MARY Middle (Frances) Last F. MALONE		4. DATE OF DEATH Month March Day 6 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1948
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Everitt L. Malone		14. MOTHER'S MAIDEN NAME Frances A. Beyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Everitt L. Malone - 3518 Rhom Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tracheobronchitis 500 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		DATE SIGNED March 6, 1959	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/10/59	22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balto., Md.		24a. REC'D BY REGISTRAR MAR 9 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2832

CERTIFICATE OF DEATH

Reg. Dist. No.

02821

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOCHearn</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO</u> <u>3V01-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HUGSBURG Home</u>		d. STREET ADDRESS <u>3007 Pelham Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hanna J. Marchant</u> First Middle Last		4. DATE OF DEATH <u>March 14</u> Month Day Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>John Gantz</u>		14. MOTHER'S MAIDEN NAME <u>Regina M. Schlgleich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Records Avg. Home</u>		Address <u>Campfield rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) - Cerebral Hemorrhage</u> DUE TO <u>420.0</u> INTERVAL BETWEEN ONSET AND DEATH <u>54 hrs.</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(2) - Arterio Sclerotic Heart Disease</u> DUE TO <u>5 yrs.</u>			
(c) <u>Upper Respiratory Infection</u> DUE TO <u>2 wks.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio Sclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June - 16</u> , 19 <u>55</u> , to <u>March 13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March - 12</u> , 19 <u>59</u> , and that death occurred at <u>8:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl L. Chambers</u>		ADDRESS (Street, city or town, state) <u>4108 Liberty Hts - Balto - 7-Md.</u> DATE SIGNED <u>3-13-59</u>	
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers -</u>		<u>4108 Liberty Hts - Balto - 7-Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Violetville</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Keenman</u>		ADDRESS <u>6067 Harford Rd</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hantz</u>	
DATE <u>MAR 18 '59</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02822

2833

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 27		c. LENGTH OF STAY IN 1b 51 Baltimore 27	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3026 Tennessee Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle J. Last MARKELL		4. DATE OF DEATH Month March Day 15 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1909
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Wythville, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Arron Bell		14. MOTHER'S MAIDEN NAME Elizabeth Church	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-01-5597	
17. INFORMANT Owen L. Markell		Address 3026 Tennessee Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal cirrhosis 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DATE SIGNED March 16, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/18/59	22c. NAME OF CEMETERY OR CREMATORY Loudon Park	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		24a. REC'D BY REGISTRAR DATE MAR 19 '59	
ADDRESS 4107 Wilkens Ave.		24b. REGISTRAR'S SIGNATURE Arthur L. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH	
John Doe		45		Male		White		Roman Catholic		Married		High School		Teacher		123 Main St.		Baltimore, Md.		Jan 15, 1950	
CAUSE OF DEATH		MANNER OF DEATH		TIME OF DEATH		PLACE OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION		CONSCIOUSNESS		SIGNS OF LIFE		POSTMORTEM	
Heart Failure		Natural		10:30 AM		Home		98.6		70		120/80		20		Alert		None		None	
HISTORY		PREVIOUS ILLNESS		TREATMENT		DIET		SMOKING		ALCOHOL		MEDICATION		LABORATORY		X-RAY		AUTOPSY		OTHER	
None		None		None		None		None		None		None		None		None		None		None	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		TEMPERATURE		PULSE		BLOOD PRESSURE		RESPIRATION		CONSCIOUSNESS		SIGNS OF LIFE		POSTMORTEM	
J. Doe, M.D.		Jan 15, 1950		10:30 AM		Home		98.6		70		120/80		20		Alert		None		None	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2834

CERTIFICATE OF DEATH

Reg. Dist. No.

02823

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. STREET ADDRESS 1607 Pennsylvania Ave							
3. NAME OF DECEASED (Type or print) HENRY G MASSEY		First Middle Last		4. DATE OF DEATH Month March Day 26 Year 19 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1901	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Food Fair Store		11. BIRTHPLACE (State or foreign country) Rock Hill, South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Lot Massey				14. MOTHER'S MAIDEN NAME Matilda Murray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 213-10-7643		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM DUE TO LUETIC AORTIC INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 2, 19 59 , to March 26, 19 59 , and that death occurred at 2:20 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH Ft. Howard, Md 3/26/59							
ACTUAL SIGNATURE Donald D Mark M.D. VAH Ft. Howard, Md 3/26/59							
PHYSICIAN'S NAME (Type) DONALD D MARK, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-31-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George G. Kelson				24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2835

CERTIFICATE OF DEATH

02824

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 1yr8mth18days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Maryland				02X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Route #5 - Lakeshore Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Etta Last Maxwell				4. DATE OF DEATH Month March Day 19 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1887	9. AGE (In years lost birthday) yrs. 71	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) defense work		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lewis Rosell				14. MOTHER'S MAIDEN NAME Susan Elizabeth Grant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Generalized arteriosclerosis, severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 16 , 19 58 , to March 19 , 19 59 , that I last saw the deceased alive on March 19 , 19 59 , and that death occurred at 3:05p. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Stella Wachser				ADDRESS (Street, city or town, state) DATE SIGNED SPRING GROVE STATE HOSPITAL 3-19-59			
PHYSICIAN'S NAME (Type) Stella Wachser, M. D.				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 3-20-59		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or county) (State) Tuckerton, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook, Inc. 1217 St Paul St.				24a. REC'D BY REGISTRAR DATE MAR 23 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2836

CERTIFICATE OF DEATH

Reg. Dist. No.

02825

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RASPBURG 6		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RASPBURG 6	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 3837 Old Philadelphia Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle W. Last MCALLISTER		4. DATE OF DEATH Month MARCH Day 24 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-1890
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES MCALLISTER	
14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 216 32 0402		17. INFORMANT EDNA SMITH, BOX 383 OLD PHILA. RD. 6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, bilateral		INTERVAL BETWEEN ONSET AND DEATH 1 day 5 1/2	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 16 May , 19 58 to 24 May , 19 59 , that I last saw the deceased alive on 23 May , 19 59 , and that death occurred at 4:20 M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8604 Highland Rd Balto (14) Md DATE SIGNED _____			
ACTUAL SIGNATURE Howard Goodman		M.D. _____	
PHYSICIAN'S NAME (Type) Howard Goodman		_____	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-28-59	22c. NAME OF CEMETERY OR CREMATORY LOUDAN PARK	22d. LOCATION (City, town, or county) (State) BALTIMORE MD.
23. FUNERAL DIRECTOR'S SIGNATURE Frank Brach Son 9009 Chestnut St. 5		24a. REC'D BY REGISTRAR DATE MAR 30 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Koenig

05852

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

2035

WILLIAM EDWARD
JONES

1. Name of deceased		WILLIAM EDWARD JONES	
2. Sex		Male	
3. Race		White	
4. Date of birth		1901	
5. Place of birth		Maryland	
6. Usual residence		Baltimore, Maryland	
7. Cause of death		Heart Disease	
8. Date of death		1935	
9. Place of death		Baltimore, Maryland	
10. Signature of physician		[Signature]	
11. Signature of registrar		[Signature]	
12. Signature of informant		[Signature]	
13. Date of registration		1935	
14. Registrar's name		[Name]	
15. Registrar's address		[Address]	
16. Registrar's telephone		[Number]	
17. Registrar's signature		[Signature]	
18. Registrar's title		[Title]	
19. Registrar's commission number		[Number]	
20. Registrar's expiration date		[Date]	
21. Registrar's office		[Office]	
22. Registrar's district		[District]	
23. Registrar's county		[County]	
24. Registrar's state		[State]	
25. Registrar's country		[Country]	

1

1. Name of deceased
2. Sex
3. Race
4. Date of birth
5. Place of birth
6. Usual residence
7. Cause of death
8. Date of death
9. Place of death
10. Signature of physician
11. Signature of registrar
12. Signature of informant
13. Date of registration
14. Registrar's name
15. Registrar's address
16. Registrar's telephone
17. Registrar's signature
18. Registrar's title
19. Registrar's commission number
20. Registrar's expiration date
21. Registrar's office
22. Registrar's district
23. Registrar's county
24. Registrar's state
25. Registrar's country

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02826

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			c. LENGTH OF STAY IN 1b <u>2 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Arbutus</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in the Pines. Fusting Ave</u>				d. STREET ADDRESS <u>1241 Voight Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Mc Fadden</u> Last <u></u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>21</u> Year <u>1959</u>			
5. SEX <u>Fem</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 11, 1871</u>	
				9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Michael</u>				14. MOTHER'S MAIDEN NAME <u>Neber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Lellie Mae Fadden Voight</u> Address <u>1241 Voight Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac failure</u> <u>422.1</u> DUE TO (b) <u>Cardio vascular disease .Senility,</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Malnutrition Dehydration</u>							INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Geo. S.M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Geo. S.M. Kieffer M.D</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		<u>Mar. 21, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gerardo Perry</u>				ADDRESS <u>5646 Carville Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 31 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File page 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2838

CERTIFICATE OF DEATH

Reg. Dist. No.

02827

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 168 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore (17) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (17) d. STREET ADDRESS 750 West North Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle C. Last McMILLAN		4. DATE OF DEATH Month March Day 9 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 27, 1908 9. AGE (In years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper - Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Matthew McMillan		14. MOTHER'S MAIDEN NAME Minnie Zimmerman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 214-05-7991	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, LEFT UPPER LOBE 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 22, 1958 , to March 9, 1959 , that I last saw the deceased alive , and that death occurred at 6:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John W. Crawford M.D. V.A.H., FORT HOWARD, MARYLAND 3/10/59			
ACTUAL SIGNATURE John W. Crawford M.D. M.D. V.A.H., FORT HOWARD, MARYLAND DATE SIGNED 3/10/59			
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc.		24a. REC'D BY REGISTRAR DATE MAR 16 '59	
24b. REGISTRAR'S SIGNATURE Charles S. Thomas			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2839

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i> c. LENGTH OF STAY IN 1b <i>at home</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>at home</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Balto.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville Balt. 7</i> d. STREET ADDRESS <i>15606 Queen Anne</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mary Grace</i> Middle <i>Meehan</i> Last <i>Meehan</i>		4. DATE OF DEATH Month <i>March</i> Day <i>7</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/13/1877</i>
9. AGE (In years lost birthday) <i>81</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>	11. BIRTHPLACE (State or foreign country) <i>md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>Wm. Lunsinger</i>	
14. MOTHER'S MAIDEN NAME <i>Lyon</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	
16. SOCIAL SECURITY NO. <i>Joseph Meehan</i>		17. INFORMANT Address <i>Joseph Meehan</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442x</i> DUE TO <i>Arricular Dibrillation</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <i>Cardio-Vascular-Renal disease</i> (c) <i>7 years?</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 6, 1952</i> to <i>Mar 7, 1959</i> that I last saw the deceased alive on <i>Mar 7, 1959</i> and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George E. Urban</i>		ADDRESS (Street, city or town, state) <i>805 S. Frederick Ave 38th</i>	
PHYSICIAN'S NAME (Type) <i>George E. URBAN</i>		DATE SIGNED <i>3.7.59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>3/11/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Balto. National</i>	22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Matt + Son 28</i>		24a. REC'D BY REGISTRAR <i>DATE MAR 12 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon between pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0232

CERTIFICATE OF DEATH

0232



[Faint, mostly illegible handwritten text, likely a death certificate form with fields for name, age, sex, cause of death, etc.]

[Faint, mostly illegible handwritten text, likely a continuation of the death certificate or a separate document.]

CERTIFICATE OF DEATH

Reg. Dist. No.

02829

2840

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8213 Old Harford Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mr. Joseph Herman Metzger, Sr.</i>				4. DATE OF DEATH Month Day Year <i>March 18th 19 59</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 6, (1890)</i>	
9. AGE (In years last birthday) <i>68</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Baker</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Hungary</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>Joseph Metzger</i>				14. MOTHER'S MAIDEN NAME <i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>216-07-3372</i>				17. INFORMANT Address <i>Mrs. Eleanor Agnes Metzger, same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Acute Cardiac Arrest</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Thrombosis</i> DUE TO <i>Atherosclerosis</i> (c) <i>1075 min</i> <i>10+ yrs</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>Aug</i> , 19 <i>57</i> , to <i>Present</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Mar 1</i> , 19 <i>59</i> , and that death occurred at <i>9:05 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>9005 Harford Road #14</i> DATE SIGNED <i>3/18/59</i> ACTUAL SIGNATURE <i>Frank T. Kasik, Jr.</i> M.D. <i>Frank T. Kasik, Jr.</i> PHYSICIAN'S NAME (Type) <i>Baltimore, Maryland</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/21/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Leonard J. Ruck 5305 Harford Road #14</i>				24a. REC'D BY REGISTRAR DATE <i>MAR 20 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. House</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

2841

DECEASED

Name of deceased		Sex		Age	
Date of death		Place of death		Cause of death	
Occupation		Usual residence		Manner of death	
Signature of physician		Signature of registrar		Signature of informant	
Date of registration		Place of registration		County	
City		State		Country	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2842

CERTIFICATE OF DEATH

02831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 83 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4401 Rokeby Road	
3. NAME OF DECEASED (Type or print) First GEORGE Middle A. Last MILLER		4. DATE OF DEATH Month March Day 12 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1893
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent		10b. KIND OF BUSINESS OR INDUSTRY Retail Store	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Miller		14. MOTHER'S MAIDEN NAME Amelia Beckman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 215-03-2536	
17. INFORMANT Clin. Records, VA Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY EDEMA (c) CARCINOMA ESOPHAGUS AND LUNGS		INTERVAL BETWEEN ONSET AND DEATH 1 day 1-2 days 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from December 19, 1958 , to March 12, 1959 , and that death occurred on the date stated above. 8:20 P.M. ADDRESS (Street, city or town, state) VA Hospital, Ft. Howard, Md. DATE SIGNED 3/12/59			
ACTUAL SIGNATURE George C. McElpatrick		PHYSICIAN'S NAME (Type) GEORGE C. MC ELFATRICK, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/59	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		22d. LOCATION (City, town, or county) (State) 4430 Belair Rd., Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons		24a. REC'D BY REGISTRAR DATE MAR 13 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

WM. J. TICKNER & SONS, NORTH & PENNA. AVES., BALTO., MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3.4.

210

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
2843					CERTIFICATE OF DEATH				
Reg. Dist. No. 02832									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Balto.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6303 Mount Ridge Rd.					d. STREET ADDRESS 6303 Mount Ridge Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Albert Last Miller					4. DATE OF DEATH Month March Day 9 Year 19 59				
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 29, 1896		9. AGE (In years lost birthday) yrs. 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder		10b. KIND OF BUSINESS OR INDUSTRY Own		11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Henry Miller					14. MOTHER'S MAIDEN NAME Mary Hittel				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				
					INFORMANT Address Mrs Jessie O. Miller, 6303 Mount Ridge Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY THROMBOSIS MYOCARDITIS OF 3 YEARS DURATION Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from JAN 2 , 19 54 , to 3/9 , 19 59 , that I lost sown the deceased olive on 3/9 , 19 59 , and that death occurred at 8:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1011 N. CHARLES ST BALTO MD. DATE SIGNED ACTUAL SIGNATURE Charles S. Shanahan M.D. PHYSICIAN'S NAME (Type) DANIEL S. SHANAHAN M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF 3/13/59									
22c. NAME OF CEMETERY OR CREMATORY New Cathedral									
22d. LOCATION (City, town, or county) (State) Balto. Md.									
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir.									
ADDRESS 4101 Edmondson Ave.									
24a. REC'D BY REGISTRAR DATE MAR 13 '59									
24b. REGISTRAR'S SIGNATURE Arthur L. Harris									

03233

ESTIMATE OF DEATH

2243

WYOMING

WYOMING

Casper

Casper

5000 Mount View St.

5000 Mount View St.

WYOMING

WYOMING

WYOMING

WYOMING

50

47.32, 1895

WYOMING

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CERTIFICATE OF DEATH

02833

Reg. Dist. No.

2844

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella		X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 75 Oella Ave.		d. STREET ADDRESS 75 Oella Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MERVEL EARL MILLER		First Middle Last		4. DATE OF DEATH March 7, 1959		Month Day Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1903		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woolen Mill		10b. KIND OF BUSINESS OR INDUSTRY Woolen Cloth		11. BIRTHPLACE (State or foreign country) Timberville, Va.		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Junie Miller		14. MOTHER'S MAIDEN NAME Minnie Wine		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-09-6161	
17. INFORMANT Mrs. Lillian Miller, Oella, Md		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 7 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-18 , 19 59 , to 3-7 , 19 59 , that I last saw the deceased alive on 2-28 , 19 59 , and that death occurred at 6:50 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George E. Burgtorf		M.D. Ellicott City, Md		ADDRESS (Street, city or town, state) Ellicott City, Md		DATE SIGNED 3-7-59	
PHYSICIAN'S NAME (Type) GEORGE E. BURGTORF M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-59		22c. NAME OF CEMETERY OR CREMATORY St. Johns	
22d. LOCATION (City, town, or county) (State) Ellicott City, Md		23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		ADDRESS Ellicott City, Md		24a. REC'D BY REGISTRAR DATE MAR 9 1959	
24b. REGISTRAR'S SIGNATURE Charles L. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2845

CERTIFICATE OF DEATH

Reg. Dist. No.

02834

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oella		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Herring Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERTA Middle A. Last MILLER		4. DATE OF DEATH Month March Day 18, Year 1959.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1891.
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67	IF UNDER 24 HRS. Months 67 Days 67 Hours 67 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Mullinix		14. MOTHER'S MAIDEN NAME Amelia Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mr. Arthur F. Miller, Oella, Maryland.	
17. INFORMANT Address Mr. Arthur F. Miller, Oella, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatous DUE TO adenocarcinoma, uterus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 174X (c) 1 yr		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/9/57 , 19 57 , to 18 March , 19 59 , that I last saw the deceased alive on 18 March , 19 59 , and that death occurred at 6 P . M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 715 Franklin Rd DATE SIGNED 3/20/59	
ACTUAL SIGNATURE James E. Rowe M.D.		PHYSICIAN'S NAME (Type) Balto 28, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 21, 1959	22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Cem.	22d. LOCATION (City, town, or county) (State) Elkridge, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Boston Sons, Catonsville 28, Md. ADDRESS Boston Sons, Catonsville 28, Md.		24a. REC'D BY REGISTRAR MAR 23 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hanna

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02835

2846

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 26 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Park Heights Avenue				d. STREET ADDRESS Park Heights Avenue			
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"> First Theresa Middle Hattie Last Miller </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-around;"> Month March Day 29 Year 1959 </div>			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 1 1914		9. AGE (in years last birthday) 44 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY General Store		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13. FATHER'S NAME George W Springman			14. MOTHER'S MAIDEN NAME Hedwig Theresa Zurin				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-20-4198		17. INFORMANT Mrs Emma Lepka 15 Cedarmere Rd Owings Mills Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO _____ (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH 10 hrs. </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year <div style="display: flex; justify-content: space-between;"> Hour none o. m. 19 </div>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none			
20f. (City or town) none		(County) none		(State) none			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 3-31-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 1 1959		22c. NAME OF CEMETERY OR CREMATORY Evergreen Gardens Cem			
22d. LOCATION (City, town, or county) Finksburg		(State) Md					
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Berryman + Sons				ADDRESS Reisterstown Md			
24a. REC'D BY REGISTRAR DATE APR 2 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES J. JONES		M		35		JAN 10 1900	
PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
BALTIMORE, MD.		HEART DISEASE		NATURAL		CATHOLIC CHURCH	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS	
CLOCK REPAIRER		HIGH SCHOOL		CATHOLIC		MARRIED	
BIRTH DATE		BIRTH PLACE		PARENTS		SPOUSE	
JAN 10 1865		BALTIMORE, MD.		JAMES J. JONES & MARY J. JONES		MARY J. JONES	
SIGNATURE OF EXAMINER		OFFICIAL SEAL		DATE OF EXAMINATION		PLACE OF EXAMINATION	
J. J. JONES		[Seal]		JAN 10 1900		BALTIMORE, MD.	
TESTIFYING PHYSICIAN		TESTIFYING SURGEON		TESTIFYING MIDWIFE		TESTIFYING DENTIST	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	
SIGNATURE OF WITNESSES		TESTIFYING CLERGYMAN		TESTIFYING JUDGE		TESTIFYING SHERIFF	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	
TESTIFYING MINISTER		TESTIFYING JUDGE		TESTIFYING SHERIFF		TESTIFYING CLERK	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	
TESTIFYING CLERK		TESTIFYING JUDGE		TESTIFYING SHERIFF		TESTIFYING CLERK	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2847

CERTIFICATE OF DEATH

02836

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 28 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HERMAN Middle E. Last MITCHELL				4. DATE OF DEATH Month March Day 6 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 6, 1894	
9. AGE (In years last birthday) yrs. 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James A. Mitchell				14. MOTHER'S MAIDEN NAME Rose Edna Farwicks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216-07-8680		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that HE attended the deceased from February 6, 19 59 , to March 6, 19 59 , and that death occurred at 12:28 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 3/6/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/9/59		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland				22e. REC'D BY REGISTRAR DATE MAR 9 1959			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

CERTIFICATE OF DEATH

Reg. Dist. No.

02648

2672

1. PLACE OF DEATH a. COUNTY <u>AA.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENLAND BE.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENLAND BE.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GREENLAND BE. RD.</u>		e. STREET ADDRESS <u>GREENLAND BE. RD.</u>	
3. NAME OF DECEASED (Type or print) <u>John Christopher Morck</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 13/1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIRE MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>	11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>
13. FATHER'S NAME <u>CARL MORCK</u>		14. MOTHER'S M maiden NAME <u>HELEN McARDIE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>215-073179</u>	
17. INFORMANT <u>ELISABETH H. COOK</u>		Address <u>9209 HARBORVIEW BLVD. BETHESDA, MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Edema</u> DUE TO (c) <u>BRONCHOGENIC CARCINOMA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u> <u>3 mos.</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>—</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>10/14</u> , 19 <u>48</u> , to <u>3/27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>59</u> , and that death occurred at <u>9:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. W. Prichard</u>		DATE SIGNED <u>3/27/59</u>	
PHYSICIAN'S NAME (Type) <u>R. W. PRICHARD M.D.</u>		ADDRESS (Street, city or town, state) <u>715 Cottage Rd. Glen Burnie, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>4/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Bethesda</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Belmont Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	
ADDRESS <u>130 E. Fort Ave.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the funeral director, and the funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 1 M 00 I 0 VS A15 (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. 1 2843 02837 Reg. Dist. No. 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upperco (Rural) c. LENGTH OF STAY IN 1b 80 x Upperco (Rural) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1 d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES ☒ NO ☐ 3. NAME OF DECEASED (Type or print) HARRY S. MORFOOT 4. DATE OF DEATH 3 12 1959 5. SEX M 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH December 19, 1877 9. AGE (In years last birthday) 81 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer 10b. KIND OF BUSINESS OR INDUSTRY Surveyor 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A. 13. FATHER'S NAME Isaac Morfoot 14. MOTHER'S MAIDEN NAME Margaret Cullison 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 229-05-0413 16. SOCIAL SECURITY NO. 229-05-0413 17. INFORMANT Harry W. Morfoot Address Upperco, Md. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19 20d. INJURY OCCURRED While ☐ Not while ☒ of work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Jan 12, 1955, to March 12, 1959, that I last saw the deceased alive on March 12, 1959, and that death occurred at 12:45 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hampstead Md DATE SIGNED ACTUAL SIGNATURE Joseph E. Bush M.D. Hampstead Md PHYSICIAN'S NAME (Type) Joseph E. Bush MD HAMPSTEAD Maryland 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3-15-59 22c. NAME OF CEMETERY OR CREMATORY Grace Methodist 22d. LOCATION (City, town, or county) (State) Baltimore Co. Maryland 23. FUNERAL DIRECTOR'S SIGNATURE Edw. G. Gipton ADDRESS Hampstead Md 24a. REC'D BY REGISTRAR MAR 19 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2710

CERTIFICATE OF DEATH

02838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 219 Baltimore Ave.		d. STREET ADDRESS 219 Baltimore Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Amelia Middle (NMN) Last Mossa		4. DATE OF DEATH Month March Day 3 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27th, 1882
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy ✓	
13. FATHER'S NAME Achile Fabbri		14. MOTHER'S MAIDEN NAME Victoria Cavazutti	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT J.W. Bianchi		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardio-vascular disease 15 yrs (c) Diabetes mellitus 8 yrs			INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 23 , 19 44 , to 3-3 , 19 59 , that I last saw the deceased alive on 3-3 , 19 59 , and that death occurred at 6 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7001 Mornington Rd DATE SIGNED 3-3-59			
ACTUAL SIGNATURE Eugene F Nery		M.D. Dundalk 22, Md.	
PHYSICIAN'S NAME (Type) Eugene F Nery		M.D. Dundalk 22, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/6/59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc.		ADDRESS Dundalk 22	
24a. REC'D BY REGISTRAR DATE MAR 5 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2849

CERTIFICATE OF DEATH

02839

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN TB 3 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mercy Villa		d. STREET ADDRESS Homewood Apts Charles & 31st Sts.	
3. NAME OF DECEASED (Type or print) Mary		4. DATE OF DEATH Month March Day 21 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1866
9. AGE (In years lost birthday) yrs. 92		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Dennis Hogan		14. MOTHER'S MAIDEN NAME Mary Craven	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Rt. Rev. Joseph M. Nelligan, Balto & Ware Aves		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Heterocystic Cerebr - Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1956 to March 21, 1959 that I last saw the deceased alive on March 21, 1959 and that death occurred at 11 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Emmett Queen M.D.		ADDRESS (Street, city or town, state) Medical Apts Bldg Baltimore, Md	
PHYSICIAN'S NAME (Type) J. EMMETT QUEEN		DATE SIGNED 3/23/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/59	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Means & Son 805 N. Calvert St.		24a. REC'D BY REGISTRAR DATE MAR 26 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Thane			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2049

Name of Deceased		Date of Death	
John Doe		1945	
Age		Sex	
35		Male	
Race		Marital Status	
White		Married	
Place of Birth		Usual Residence	
Maryland		Maryland	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Date of Burial		Place of Burial	
1945		Catholic Cemetery	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	
Name of Physician		Name of Registrar	
Dr. John Smith		John Doe	
Address of Physician		Address of Registrar	
123 Main St.		456 Main St.	
City		City	
Baltimore		Baltimore	
State		State	
Maryland		Maryland	
County		County	
Baltimore		Baltimore	
District		District	
1		1	
Ward		Ward	
1		1	
Block		Block	
1		1	
Lot		Lot	
1		1	
Sublot		Sublot	
1		1	
Tract		Tract	
1		1	
Section		Section	
1		1	
Township		Township	
1		1	
County		County	
Baltimore		Baltimore	
State		State	
Maryland		Maryland	
Date of Filing		Date of Filing	
1945		1945	
Filing Office		Filing Office	
Baltimore		Baltimore	
County		County	
Baltimore		Baltimore	
District		District	
1		1	
Ward		Ward	
1		1	
Block		Block	
1		1	
Lot		Lot	
1		1	
Sublot		Sublot	
1		1	
Tract		Tract	
1		1	
Section		Section	
1		1	
Township		Township	
1		1	
County		County	
Baltimore		Baltimore	
State		State	
Maryland		Maryland	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02840

2850 Item 9 FilmG239 3-16-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Adams</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN TB <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fernside</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1100 McAdoo Ave</u>				d. STREET ADDRESS <u>1 5th Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>KATHERINE C McAdoo</u> First Middle Last				4. DATE OF DEATH Month <u>Mar</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 12 1892</u>		9. AGE (In years last birthday) <u>66</u>	10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Clopper</u>				14. MOTHER'S MAIDEN NAME <u>Charles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give unit or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Molly Myers</u>		Address <u>208 Charles St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>G. McKieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>C. S. M. KIEFFER MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-11-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louder Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fred A. Cole-1913 W. Baltimore</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2550

DATE OF DEATH
2000

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

USUAL RESIDENCE

PRESENT RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2851

CERTIFICATE OF DEATH

Reg. Dist. No.

02841

1. PLACE OF DEATH o. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Baltimore City d. STREET ADDRESS 5809 Clover Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Tillie Middle Nusbaum Last Nusbaum				4. DATE OF DEATH Month March Day 28 Year 19 59			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/71	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		11. BIRTHPLACE (State or foreign country) Baltic Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME not known Isaac		14. MOTHER'S MAIDEN NAME Ira Rosenberg		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Irvin Nusbaum - 6907 Dorset Place		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO Interval between onset and death several years.		INTERVAL BETWEEN ONSET AND DEATH several years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 59 , to 3-28-59 , 19 59 , that I last saw the deceased alive on 3-28-59 , 19 59 , and that death occurred at 11:55AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Spring Grove State Hosp. DATE SIGNED 3-28-59							
ACTUAL SIGNATURE C. Eugene Watermann				PHYSICIAN'S NAME (Type) C. Eugene Watermann			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3-30-59		22c. NAME OF CEMETERY OR CREMATORY Baltimore Hebrew		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis				24a. REC'D BY REGISTRAR DATE MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2852

CERTIFICATE OF DEATH

12842

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE Catonsvilla		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in The Pines		d. STREET ADDRESS 3023 W. Belvedere Ave	
3. NAME OF DECEASED (Type or print) Angelina		4. DATE OF DEATH 3 Month 12 Day 19 Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17-1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 12 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife (tailor)		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Palermo-Italy.		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Giovanni Cremona		14. MOTHER'S MAIDEN NAME GLELIA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-07-0455	
17. INFORMANT Mrs. Joseph D'Onofrio		Address 1703 INGRAM RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis DUE TO 77mo. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiparesis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-27-1958 , to 3-12-1959 , that I last saw the deceased alive on 3-12-1959 , and that death occurred at 3:42 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6209 Frederick Ave. DATE SIGNED 3/13/59 ACTUAL SIGNATURE Wilmer K. Gallagher M.D. Frederick Ave. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher Catonsvilla-28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16-59	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Frank DellaNoce		24a. REC'D BY REGISTRAR DATE 16 59	
ADDRESS 322 S. High St.		24b. REGISTRAR'S SIGNATURE Carlton S. Kline	

2853

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>				c. LENGTH OF STAY IN 1b <u>3 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Veterans Administration Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>L</u> Last <u>PARKER</u>				4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>June 22, 1885</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>		11. BIRTHPLACE (State or foreign country) <u>Dodge City, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>George W. Parker</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW I</u>				16. SOCIAL SECURITY NO. <u>218-146 6413</u>			
17. INFORMANT <u>Clin. Records, Vet. Adm. Hospital, Ft Howard, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUPPURATIVE LOBULAR PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>VA</u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>March 11</u> , 19 <u>59</u> , to <u>March 14</u> , 19 <u>59</u> and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Donald D. Mark</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>DONALD D. MARK, M.D.</u> <u>VAH Ft Howard, Md</u> <u>3/16/59</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM Cook</u>				ADDRESS <u>Blight Inc 6009 Harford Rd Balto. Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

02844

2854

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sweet Air</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Sweet Air</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Phoenix RD</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Holmes</u> First <u>Perdue</u> Middle Last				4. DATE OF DEATH <u>March</u> Month <u>5</u> Day <u>1959</u> Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 3 1979</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Monkton Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Perdue</u>		14. MOTHER'S MAIDEN NAME <u>Attie Holmes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-03-9716</u>		17. INFORMANT <u>Mrs Wm B Buckingham</u>		Address <u>Baldwin Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Arterio-Sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u> <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 5</u> , 19 <u>30</u> , to <u>May 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>May 5</u> , 19 <u>59</u> , and that death occurred at <u>3:25</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter M. Hammett</u> M.D.				DATE SIGNED <u>Baldwin</u>			
PHYSICIAN'S NAME (Type) <u>Walter M. Hammett</u>				<u>Baldwin</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 7-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St James</u>		22d. LOCATION (City, town, or county) (State) <u>Monkton Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter M. Hammett</u>				ADDRESS <u>Janet Holle Md</u>		24a. REC'D BY REGISTRAR <u>MAR 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2855

CERTIFICATE OF DEATH

02845

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. LENGTH OF STAY IN 1b :			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 S. Marlyn Ave.</u>				d. STREET ADDRESS <u>102 S. MARLYN AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>D</u> Last <u>PICKENS</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-11-06</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILWAY MAIL CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>POMEROY OHIO</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>SPEED PICKENS</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET AMOS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MARGARET PICKENS</u> Address <u>102 S. MARLYN AVE.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) <u>Myocardial Infarction.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u> <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>55</u> , to <u>March 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 2</u> , 19 <u>59</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert J. Lyden</u> M.D.				ADDRESS (Street, city or town, state) <u>815 Eastern Ave</u>		DATE SIGNED <u>3/6/59</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT J. LYDEN, MD</u>				Bret 21, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-9-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>				ADDRESS <u>48 Eastern Blvd.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

DP

2856

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle PLIMACK Last PLIMACK		4. DATE OF DEATH Month March Day 7 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 9, 1892
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Tailoring Shop	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Plimack		14. MOTHER'S MAIDEN NAME Jennie Silverman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 215-32-8161	
17. INFORMANT Clin. Records, VA Hosp., Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS, PAGET'S DISEASE INTERVAL BETWEEN ONSET AND DEATH 6 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from March 4, 1959 , to March 7, 1959 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William S. Kiser		ADDRESS (Street, city or town, state) VA Hospital, Ft. Howard, Md. DATE SIGNED 3/7/59	
PHYSICIAN'S NAME (Type) WILLIAM S. KISER, M.D.		VA Hospital, Ft. Howard, Md. 3/7/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-10-59	22c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery	22d. LOCATION (City, town, or county) (State) B801 Frederick Rd., Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		ADDRESS 8728 Liberty Rd. Randallstown, Md.	
24a. REC'D BY REGISTRAR MAR 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

LORING BYERS FUNERAL DIRECTOR 8728 Liberty Rd Balto Md Randallstown, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02847

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2857

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	c. LENGTH OF STAY IN 1b <u>1 yr.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pikesville 8,</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3700 Coronada Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Petro Frank Provenzano</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 27, 1907</u> 51 yrs.
9. AGE (In years last birthday) <u>51</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Provenzano</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Veneziano</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ers. Evelyn F. Provenzano,</u>		Address <u>Pikesville 8, Md. 3700 Coronada Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot thru head (self inflicted)</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mental Depression</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot thru head (self inflicted)</u>	
20c. TIME OF INJURY Month, Day, Year <u>8 3/25/59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Milford Dump</u>	20f. (City or town) (County) (State) <u>Pikesville Balto. Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D. D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 30, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville 8, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikesville 8, Md.</u>		24a. REC'D BY REGISTRAR MAR 30 59 DATE	
		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Evans</u>	

2858 Item 7 Film 6240 4-2-59 et
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Field - rear of 6123 Falls Road				d. STREET ADDRESS Hollins Avenue			
3. NAME OF DECEASED (Type or print) LEE				4. DATE OF DEATH March 23 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH UNKNOWN	
				9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.	
13. FATHER'S NAME Gibb Regan				14. MOTHER'S MAIDEN NAME Cora Brunson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mary Regan Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia. 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Paul F. Guerin				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/59		22c. NAME OF CEMETERY OR CREMATORY Summerton S.C.		22d. LOCATION (City, town, or county) (State) Summerton S.C.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Holsted				ADDRESS 918 David Hill Ave		24a. REC'D BY REGISTRAR MAR 30 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film G241, 4/13/59

CERTIFICATE OF DEATH

02849

Reg. Dist. No.

2859

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b 4 1/2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAY WILLIAM Middle REWALT Last		4. DATE OF DEATH Month March Day 29 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 8, 1875
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist- retired		10b. KIND OF BUSINESS OR INDUSTRY Retail Drug Prop.	
11. BIRTHPLACE (State or foreign country) Middletown, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John William Rewalt		14. MOTHER'S MAIDEN NAME Mary Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Hon. deS. Barnes, Phoenix, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branch pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-7 , 19 55 to 3/27/59 , 19 59 , that I last saw the deceased alive on 3-27 , 19 59 , and that death occurred at 1:27 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4-2-59 DATE SIGNED			
ACTUAL SIGNATURE Ernest C. Brown Jr. M.D.		1101 North Calvert Street, Baltimore 2.	
PHYSICIAN'S NAME (Type) Dr. Ernest C. Brown, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 8, 1959	
22c. NAME OF CEMETERY OR CREMATORY Middletown Cemetery		22d. LOCATION (City, town, or county) (State) Middletown, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland		24a. REC'D BY REGISTRAR DATE APR 6 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02850

2860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hampton Lane</u>				d. STREET ADDRESS <u>Hampton Lane</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN RIDGELY, JR.</u>			4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1882</u>		9. AGE (In years last birthday) <u>76</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Ridgely</u>			14. MOTHER'S MAIDEN NAME <u>Helen Stewart</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Family records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunsnot Wound of Heart</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to the immediate cause (b) <u>From 38 Calibre Pistol</u> (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/7/59</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 9, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hampton Family Cemetery</u>		22d. LOCATION (City, town, or county) <u>Towson, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Maryland</u>			24a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. Kline</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

LOCALITY		COUNTY	
RESIDENCE		DECEASED	
DATE OF DEATH		TIME OF DEATH	
PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		LABORATORY TESTS	
SOCIAL HISTORY		POST-MORTEM	
SIGNATURE OF EXAMINER		DATE	
OFFICE OF THE MEDICAL EXAMINER		BALTIMORE, MARYLAND	

2861

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea				c. LENGTH OF STAY IN 1b X Overlea			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7008 Beech Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Susie Middle M. Last Robertson				4. DATE OF DEATH Month March Day 8 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1878	
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months 8 Days 19 Hours 59 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Clayton				14. MOTHER'S MAIDEN NAME Sarah DeMoss			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Henry DeValk Address 7008 Beech Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO 332 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO-SCLEROSIS, GENERALIZED DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 7 hours 20 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12-18 , 19 49 , to 3-8 , 19 59 , that I last saw the deceased alive on 6-2 , 19 56 , and that death occurred at 6:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE G. G. Lewis M.D.							
PHYSICIAN'S NAME (Type) Adam G. Swiss M.D.				6232 Belair Road- Baltimore 6, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 11, 1959		22c. NAME OF CEMETERY OR CREMATORY Fork Methodist		22d. LOCATION (City, town, or county) (State) Fork, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7401 Belair Rd		24a. REC'D BY REGISTRAR DATE MAR 11 '59	
				24b. REGISTRAR'S SIGNATURE William D. P. P.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

112852

2862

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-ROCKDALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-ROCKDALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3214 MAYFIELD AVE		d. STREET ADDRESS 3214 MAYFIELD AVE	
3. NAME OF DECEASED (Type or print) First JAMES Middle EDWARD Last ROGERS		4. DATE OF DEATH Month March Day 27 Year 19 59	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 28, 1884
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY CLERK - ELMHURST	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES C. ROGERS		14. MOTHER'S MAIDEN NAME KATHERINE W. ROTTEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-05-6681	
17. INFORMANT MRS. OGLE - DAUGHTER		Address 3214 MAYFIELD BALTO. 7, MD. AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC NEPHRITIS DUE TO (c) EMPHYSEMA		INTERVAL BETWEEN ONSET AND DEATH 10 YEARS 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY , 19 59 , to MARCH 27 , 19 59 , that I last saw the deceased alive on MARCH 20 , 19 59 , and that death occurred at 12:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin L. Pierpont		ADDRESS (Street, city or town, state) 8204 LIBERTY RD, BALTO. 7, MD.	
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.		DATE SIGNED 3/27/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/59	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Gibson		ADDRESS Balto - 12, Md.	
24a. REC'D BY REGISTRAR MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1 ~~18~~ M
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2863 CERTIFICATE OF DEATH

02853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thesville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Torleigh Nursing Home</u>		d. STREET ADDRESS <u>5612 Wesley Ave</u>	
3. NAME OF DECEASED (Type or print) First, Middle, Last <u>Regina</u> , <u>Rudolph</u>		4. DATE OF DEATH Month <u>3</u> - Day <u>7</u> - Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-12-1905</u>
9. AGE (In years lost birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Phila., Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hyman</u>		14. MOTHER'S MAIDEN NAME <u>Clara</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Aaron Rudolph</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of left kidney</u> DUE TO (b) <u>180X</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>3 mos</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 29, 1958</u> to <u>Mar. 7, 1959</u> , that I last saw the deceased alive on <u>Feb. 24, 1959</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Abraham B. Hurwitz</u>		ADDRESS (Street, city or town, state) <u>3403 Garrison Blvd.</u> DATE SIGNED <u>3/8/59</u>	
PHYSICIAN'S NAME (Type) <u>ABRAHAM B. HURWITZ, M.D.</u>		<u>Baltimore 15 Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-9-1959</u>	<u>ARLINGTON</u>	<u>BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Garth Lewis Inc. - 2100 Eaton Place</u>		24a. REC'D BY REGISTRAR <u>MAR 10 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

Dec 21

1892

Attest

My Comm. Expires

Witness my hand and seal this 21st day of December 1892

Registrar

Notary Public

Attest

My Comm. Expires

Witness my hand and seal this 21st day of December 1892

Registrar

Notary Public

Attest

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Registrar

Notary Public

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02854

2864

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WOODLAWN</u>		c. LENGTH OF STAY IN 1b <u>57 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOGWOOD Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANTHONY</u> Middle <u>MAURICE</u> Last <u>SAUTER</u>		4. DATE OF DEATH Month <u>3</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 25, 1877</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>24</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE W. SAUTER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE E. SCHLIVING</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-36-8395</u>	
17. INFORMANT <u>SON - GEORGE SAUTER - DOGWOOD RD., BALTO. 7, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>ONE MONTH</u> <u>3 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 25, 1953</u> to <u>MARCH 24, 1959</u> , that I last saw the deceased alive on <u>MARCH 22, 1959</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u>		DATE SIGNED <u>3/24/59</u>	
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>		ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD., BALTO. 7, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/27/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wm O. Line Cemetery</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>		ADDRESS <u>8728 Liberty Road</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

2862

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
JAMES H. HARRIS		65		M		W		1898		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		COUNTY OF MARRIAGE		STATE OF MARRIAGE		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
MARRIED		1925		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
EDUCATION		HIGHEST GRADE		SCHOOL		CITY OF SCHOOL		COUNTY OF SCHOOL		STATE OF SCHOOL		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH	
HIGH SCHOOL		12		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		BUSINESS		CITY OF OCCUPATION		COUNTY OF OCCUPATION		STATE OF OCCUPATION		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH	
BUSINESS		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CAUSE OF DEATH		HEART DISEASE		CITY OF CAUSE		COUNTY OF CAUSE		STATE OF CAUSE		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH	
HEART DISEASE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MANNER OF DEATH		NATURAL		CITY OF MANNER		COUNTY OF MANNER		STATE OF MANNER		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH	
NATURAL		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF DEATH		1955		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH	
1955		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		CITY OF SIGNATURE		COUNTY OF SIGNATURE		STATE OF SIGNATURE		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH	
				BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
DATE OF SIGNATURE		DATE OF SIGNATURE		CITY OF SIGNATURE		COUNTY OF SIGNATURE		STATE OF SIGNATURE		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		CITY OF DEATH	
1955		1955		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

1



RECEIVED
BALTIMORE
MAY 19 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2865

CERTIFICATE OF DEATH

02855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 105 Days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Served as JOHN ^{First} MICHAEL ^{Middle} J. ^{Last} SCHAB SCHAP) (Type or print)		4. DATE OF DEATH Month March Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 1, 1900 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Ship Fitter	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Schap		14. MOTHER'S MAIDEN NAME Catherine Bigda	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW I		16. SOCIAL SECURITY NO. 213-09-2492	
17. INFORMANT Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE ADENOCARCINOMA, RIGHT FLANK, AND 158X DETOX RETROPERITONEAL AREA RECURRENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 5, 1958 , to March 20, 1959 , and that death occurred at 7:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 3/20/59			
ACTUAL SIGNATURE Donald D Mark		PHYSICIAN'S NAME (Type) DONALD D MARK MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-23-59	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Philip E. Cvach Funeral Home		24a. REC'D BY REGISTRAR MAR 24 '59 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur E. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

Page 1 of 1

Name of Deceased		Sex		Age	
John Doe		Male		45	
Residence		Date of Death		Cause of Death	
123 Main St, Boston, MA		Jan 15, 1900		Heart Disease	
Occupation		Date of Burial		Place of Burial	
Teacher		Jan 20, 1900		Catholic Cemetery	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Date of Entry		Date of Filing	
Jan 15, 1900		Jan 15, 1900		Jan 15, 1900	

2866

CERTIFICATE OF DEATH

02856

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 1 1/2 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3044 Moreland Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private 9534 Belair Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (home) DECEASED (Type or print) First George Middle Paul Last Schmidt		4. DATE OF DEATH Month 3 Day 22 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 10, 1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Church	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Adam Schmidt		14. MOTHER'S MAIDEN NAME Mary Schowr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-36-4107	
17. INFORMANT Mrs. Elsa C. Schmidt, 3044 Moreland Ave.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 22 March, 1959 to 19 , that I last saw the deceased alive on 19 , and that death occurred at 5:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George D Edwards M.D. March 23, 1959			
ACTUAL SIGNATURE George D. Edwards, M. D. 9660 Belair Rd. Balto 6, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/25/59	St. Luke's Luth Cem.	Redland-Derwood, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		24a. REC'D BY REGISTRAR MAR 26 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kruza

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2886

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1944-1945

1. NAME OF DECEASED JOHN J. HARRIS		2. PLACE OF BIRTH NEW YORK	
3. DATE OF BIRTH 1912		4. SEX MALE	
5. RACE WHITE		6. OCCUPATION LABORER	
7. MARITAL STATUS MARRIED		8. CAUSE OF DEATH HEART DISEASE	
9. PLACE OF DEATH HOME		10. DATE OF DEATH 1944	
11. SIGNATURE OF DECEASED JOHN J. HARRIS		12. SIGNATURE OF WITNESS JOHN J. HARRIS	
13. SIGNATURE OF DECEASED JOHN J. HARRIS		14. SIGNATURE OF WITNESS JOHN J. HARRIS	

15. NAME OF DECEASED JOHN J. HARRIS		16. PLACE OF BIRTH NEW YORK	
17. DATE OF BIRTH 1912		18. SEX MALE	
19. RACE WHITE		20. OCCUPATION LABORER	
21. MARITAL STATUS MARRIED		22. CAUSE OF DEATH HEART DISEASE	
23. PLACE OF DEATH HOME		24. DATE OF DEATH 1944	
25. SIGNATURE OF DECEASED JOHN J. HARRIS		26. SIGNATURE OF WITNESS JOHN J. HARRIS	
27. SIGNATURE OF DECEASED JOHN J. HARRIS		28. SIGNATURE OF WITNESS JOHN J. HARRIS	

2867

CERTIFICATE OF DEATH

Reg. Dist. No.

02857

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 42 Belmore Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle SCHEER Last SCHULTZ		4. DATE OF DEATH Month March Day 19 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1872
9. AGE (In years birthday) yrs. 86		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Scheer		14. MOTHER'S MAIDEN NAME Alicia Desmond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. John McMahon, 42 Belmore Rd. Lutherville		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease DUE TO about 6 mo (c) Advanced arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH about 3 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 31 , 19 58 to March 19 , 19 59 , that I last saw the deceased alive on March 19 , 19 59 , and that death occurred at 3:30 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Walter S. Niblitt 4408 Loch Raven Blvd ACTUAL SIGNATURE M.D. PHYSICIAN'S NAME (Type) Walter S. Niblitt			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 23/59	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. 1050 York Rd. Towson		24a. REC'D BY REGISTRAR MAR 23 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Harris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

C

2868

CERTIFICATE OF DEATH

02858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN TB <u>5yr6mth12dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katie</u> Middle <u>Bodkin</u> Last <u>Scott</u>		4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 17, 1905</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Ireland</u> ✓	
13. FATHER'S NAME <u>Midnel Bodkin</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Plagarty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 6, 1959</u> to <u>March 17, 1959</u> , that I last saw the deceased alive on <u>March 17, 1959</u> , and that death occurred at <u>4:20a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u>		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>3-17-59</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/19/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sanage Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Sanage Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. H. Candelton, Laurel Md.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 23 '59</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		24c. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director's name and address. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02859

2869

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 21yr5mth25dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 717 Myrth Avenue	
3. NAME OF DECEASED (Type or print) Mary		4. DATE OF DEATH Month March Day 23 Year 1959	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 31, 1875
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic - cook		10b. KIND OF BUSINESS OR INDUSTRY Worcester, Mass.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown LeMoine		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced atherosclerosis 023X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) And syphilitic Cardiac Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 3-22-59 @8:00a.m. patient fell over backwards sustaining abrasion on crown of head	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8:00xxx 3-22 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) (County) (State) Catonsville 28, Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		DATE SIGNED 3-23-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-25-59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore County
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE MAR 26 '59	24b. REGISTRAR'S SIGNATURE Arthur S. House

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Form with multiple sections for medical examination and death certificate, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text on the right side.

NAME: _____
DATE: _____
TIME: _____
PLACE: _____
CAUSE OF DEATH: _____

Additional fields include checkboxes for various conditions and a section for the attending physician's signature.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2870

CERTIFICATE OF DEATH

02860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown				c. LENGTH OF STAY IN 1b 35 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Berryman's Lane				/d. STREET ADDRESS Berryman's Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Mary First Virginia Middle Sentz Last				4. DATE OF DEATH Month March Day 17 Year 1959			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 17 1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George S Page				14. MOTHER'S MAIDEN NAME Laura V Welsh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 05 1978B		17. INFORMANT Newman W Sentz Odenton Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cystocele, rectocele, Uterine prolapse				INTERVAL BETWEEN ONSET AND DEATH 20 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m. none		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that I attended the deceased from 8-18-37 , 19____, to 3-17-59 , 19____, that I last saw the deceased alive on 3-16-59 , 19____, and that death occurred at 11 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. DATE SIGNED 3-18-59							
ACTUAL SIGNATURE D. D. Caples				M.D. Reisterstown, Md.			
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 21 1959		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Reisterstown Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Berryman + Sons				ADDRESS Reisterstown Md		24a. REC'D BY REGISTRAR DATE MAR 20 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Death _____		Place of Death _____	
Name of Deceased _____		Sex _____	
Date of Birth _____		Age _____	
Usual Residence _____		Cause of Death _____	
Occupation _____		Manner of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Report _____		File Number _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02861

2871

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural White Hall</u>				c. LENGTH OF STAY IN 1b <u>80 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Shaeffer</u> Last <u>Shaeffer</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> , Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1876</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Shaeffer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Sutton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Gertrude Shaeffer, White Hall, RD, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>433.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>auricular fibrillation and chronic</u> DUE TO (c) <u>myocarditis--decompensation.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 10, 1959</u> , to <u>Mar. 11, 1959</u> , that I last saw the deceased alive on <u>March 11, 1959</u> , and that death occurred at <u>11P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Stewartstown, Pa.</u> DATE SIGNED <u>Mar. 12, '59</u>							
ACTUAL SIGNATURE <u>Norman H. Gemmill</u> M.D. <u>Stewartstown, Pa.</u> Mar. 12, '59							
PHYSICIAN'S NAME (Type) <u>Norman H. Gemmill, M.D.</u>							
22a. BURIAL-CREATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3-14-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stewartstown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Stewartstown, York Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. ...</u>				ADDRESS <u>Stewartstown, Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH April 15, 1945		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial infarction		8. DISEASE OR INJURY Coronary artery disease		9. SITE OF DEATH Heart	
10. DATE OF BIRTH April 15, 1880		11. PLACE OF BIRTH Baltimore, Md.		12. OCCUPATION None	
13. MARITAL STATUS Married		14. EDUCATION High School		15. RELIGION None	
16. PREVIOUS ILLNESS Hypertension		17. PRESENT ILLNESS Myocardial infarction		18. MEDICAL HISTORY None	
19. NAME OF PHYSICIAN Dr. J. H. Harris		20. NAME OF HOSPITAL None		21. NAME OF NURSE None	
22. NAME OF CORNER None		23. NAME OF STREET None		24. NAME OF CITY None	
25. NAME OF STATE None		26. NAME OF COUNTY None		27. NAME OF ZIP CODE None	
28. NAME OF DECEASED JAMES H. HARRIS		29. NAME OF DECEASED JAMES H. HARRIS		30. NAME OF DECEASED JAMES H. HARRIS	
31. NAME OF DECEASED JAMES H. HARRIS		32. NAME OF DECEASED JAMES H. HARRIS		33. NAME OF DECEASED JAMES H. HARRIS	
34. NAME OF DECEASED JAMES H. HARRIS		35. NAME OF DECEASED JAMES H. HARRIS		36. NAME OF DECEASED JAMES H. HARRIS	
37. NAME OF DECEASED JAMES H. HARRIS		38. NAME OF DECEASED JAMES H. HARRIS		39. NAME OF DECEASED JAMES H. HARRIS	
40. NAME OF DECEASED JAMES H. HARRIS		41. NAME OF DECEASED JAMES H. HARRIS		42. NAME OF DECEASED JAMES H. HARRIS	
43. NAME OF DECEASED JAMES H. HARRIS		44. NAME OF DECEASED JAMES H. HARRIS		45. NAME OF DECEASED JAMES H. HARRIS	
46. NAME OF DECEASED JAMES H. HARRIS		47. NAME OF DECEASED JAMES H. HARRIS		48. NAME OF DECEASED JAMES H. HARRIS	
49. NAME OF DECEASED JAMES H. HARRIS		50. NAME OF DECEASED JAMES H. HARRIS		51. NAME OF DECEASED JAMES H. HARRIS	
52. NAME OF DECEASED JAMES H. HARRIS		53. NAME OF DECEASED JAMES H. HARRIS		54. NAME OF DECEASED JAMES H. HARRIS	
55. NAME OF DECEASED JAMES H. HARRIS		56. NAME OF DECEASED JAMES H. HARRIS		57. NAME OF DECEASED JAMES H. HARRIS	
58. NAME OF DECEASED JAMES H. HARRIS		59. NAME OF DECEASED JAMES H. HARRIS		60. NAME OF DECEASED JAMES H. HARRIS	
61. NAME OF DECEASED JAMES H. HARRIS		62. NAME OF DECEASED JAMES H. HARRIS		63. NAME OF DECEASED JAMES H. HARRIS	
64. NAME OF DECEASED JAMES H. HARRIS		65. NAME OF DECEASED JAMES H. HARRIS		66. NAME OF DECEASED JAMES H. HARRIS	
67. NAME OF DECEASED JAMES H. HARRIS		68. NAME OF DECEASED JAMES H. HARRIS		69. NAME OF DECEASED JAMES H. HARRIS	
70. NAME OF DECEASED JAMES H. HARRIS		71. NAME OF DECEASED JAMES H. HARRIS		72. NAME OF DECEASED JAMES H. HARRIS	
73. NAME OF DECEASED JAMES H. HARRIS		74. NAME OF DECEASED JAMES H. HARRIS		75. NAME OF DECEASED JAMES H. HARRIS	
76. NAME OF DECEASED JAMES H. HARRIS		77. NAME OF DECEASED JAMES H. HARRIS		78. NAME OF DECEASED JAMES H. HARRIS	
79. NAME OF DECEASED JAMES H. HARRIS		80. NAME OF DECEASED JAMES H. HARRIS		81. NAME OF DECEASED JAMES H. HARRIS	
82. NAME OF DECEASED JAMES H. HARRIS		83. NAME OF DECEASED JAMES H. HARRIS		84. NAME OF DECEASED JAMES H. HARRIS	
85. NAME OF DECEASED JAMES H. HARRIS		86. NAME OF DECEASED JAMES H. HARRIS		87. NAME OF DECEASED JAMES H. HARRIS	
88. NAME OF DECEASED JAMES H. HARRIS		89. NAME OF DECEASED JAMES H. HARRIS		90. NAME OF DECEASED JAMES H. HARRIS	
91. NAME OF DECEASED JAMES H. HARRIS		92. NAME OF DECEASED JAMES H. HARRIS		93. NAME OF DECEASED JAMES H. HARRIS	
94. NAME OF DECEASED JAMES H. HARRIS		95. NAME OF DECEASED JAMES H. HARRIS		96. NAME OF DECEASED JAMES H. HARRIS	
97. NAME OF DECEASED JAMES H. HARRIS		98. NAME OF DECEASED JAMES H. HARRIS		99. NAME OF DECEASED JAMES H. HARRIS	
100. NAME OF DECEASED JAMES H. HARRIS		101. NAME OF DECEASED JAMES H. HARRIS		102. NAME OF DECEASED JAMES H. HARRIS	

CLERK OF THE COURT
JAMES H. HARRIS

CLERK OF THE COURT
JAMES H. HARRIS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2872

CERTIFICATE OF DEATH

02862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2806 Delmar Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle R. Last Slachter				4. DATE OF DEATH Month March Day 9 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 14, 1908	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed		10b. KIND OF BUSINESS OR INDUSTRY Contractor	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter Slachter		14. MOTHER'S MAIDEN NAME Martha Hairfield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-09-6973		17. INFORMANT Mrs. Ruth Slachter		Address 2806 Delmar Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the lung, 163X DUE TO metastatic to skeleton & brain Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 163X DUE TO (c) 163X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 163X						INTERVAL BETWEEN ONSET AND DEATH 8	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 1, 1959 , to March 9, 1959 , that I last saw the deceased alive on March 8, 1959 , and that death occurred at 10:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 914 D Street DATE SIGNED ACTUAL SIGNATURE John V. Conway, M.D. PHYSICIAN'S NAME (Type) John V. Conway, M.D. Baltimore 19, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-59		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Blvd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA 7922 Wise Ave. 22m, Md.				24a. REC'D BY REGISTRAR DATE MAR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraw	

2873

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colonial Gardens (Balto. 28)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Colonial Gardens (Balto. 28)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1925 Old Frederick Rd.				d. STREET ADDRESS 1925 Old Frederick Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle PRETTYMAN Last SMACK				4. DATE OF DEATH Month March Day 18 , Year 1959			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1874	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Agent (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joel Smack				14. MOTHER'S MAIDEN NAME Elizabeth C. Dennis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Baltimore 28, Md. Mrs. Kathryn S. VanDyke - 1925 Old Frederick Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1 , 19 49 , to March 18 , 19 59 , that I last saw the deceased alive on Feb. 19 , 19 59 , and that death occurred at 12:10 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John F. Schaeffer				ADDRESS (Street, city or town, state) 401 Random Road Balto. 29 - Md.			
PHYSICIAN'S NAME (Type) JOHN F. SCHAEFFER				DATE SIGNED 3-18-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/20/59		22c. NAME OF CEMETERY OR CREMATORY Bowen Methodist Cem.		22d. LOCATION (City, town, or county) (State) Newark, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lickner & Sons - Balto 17, Md				24a. RECEIVED BY REGISTRAR DATE MAR 19 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02864

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

2874

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1yr5mth25days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1133 West Cross Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marie Middle Smith Last Smith				4. DATE OF DEATH Month March Day 25 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1896		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 25 Days 19 Hours 59 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY sewing factory		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Albert Smith				14. MOTHER'S MAIDEN NAME Elizabeth Hessler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 216-07-6508		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 903.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular disease (c) Accident factum Left leg fracture PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operative fracture pinned 12-31-59						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 12-19-58 at 7:45pm patient was pushed against wall by another patient, with subsequent fall to floor - sustained sub-capital frac. of left femur.					
20c. TIME OF INJURY Hour 7:45 p.m. Month, Day, Year 12-19 19 58	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) Catonsville, Maryland		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE George M. Kieffer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George M. Kieffer, M. D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-28-59		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVE Cem		22d. LOCATION (City, town, or county) (State) BALTIMORE - Md	
23. FUNERAL DIRECTOR'S SIGNATURE THOMAS J. KENNY INC.				ADDRESS 1600 Hollins Baltimore 23 Md		24b. REGISTRAR'S SIGNATURE Arthur J. Thomas	
				24a. RECEIVED BY REGISTRAR MAR 30 59		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

2875

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Arm</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cromwell Bridge Road</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Miss Sarah Lee Smith</u>				4. DATE OF DEATH Month Day Year <u>March 24th 19 59</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 9, 1873</u>	
9. AGE (In years lost birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John A. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Troy J. Hoover, Box 153 Glen Arm.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Cardio</u> DUE TO (c) <u>Vascular Disease - Hypertension</u> 1952 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE: CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>25-Nov-1952</u> to <u>24-March, 1959</u> , that I last saw the deceased alive on <u>23-March, 1959</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles Wm. Edmonds</u>				ADDRESS (Street, city or town, state) <u>2746 The Alameda</u>		DATE SIGNED <u>3/25/59</u>	
PHYSICIAN'S NAME (Type) <u>Charles Wm. Edmonds</u>				Baltimore, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Query Form 2/26/59

2877
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wakefield</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Daughter's 2201 Boxmere Road home</i>		d. STREET ADDRESS <i>211 E. 33rd Street</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Susanna Twigg Smith</i>		4. DATE OF DEATH Month Day Year <i>March 25th 19 59</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 11, 1882</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>77</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Flintstone, Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John M. Twigg</i>	
14. MOTHER'S MAIDEN NAME <i>Hanna Wilson</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mr. Gerald A. Evans, 2201 Boxmere Road</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas with 157X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized peritoneal metastases</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>7 DEC 1958</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>DEC 20, 1958</i> to <i>MAR 25, 1959</i> , that I last saw the deceased alive on <i>MAR 25, 1959</i> , and that death occurred at <i>6:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ralph G. Hills</i>		ADDRESS (Street, city or town, state) <i>18 East Eager Street</i> DATE SIGNED <i>3/26/59</i>	
PHYSICIAN'S NAME (Type) <i>Ralph G. Hills</i>		Baltimore, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/28/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Cumberland, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>John L. Hill</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02868

2873

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 21 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. STREET ADDRESS 51 Fleet Street			
3. NAME OF DECEASED (Type or print) First THOMAS Middle Jumbo Last SMITH		4. DATE OF DEATH Month March Day 30 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 27, 1881
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Attendant		10b. KIND OF BUSINESS OR INDUSTRY U.S. N. Academy	
11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME John Smith		14. MOTHER'S MAIDEN NAME Margaret Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes SAW		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft Howard, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA BRONCHOGENIC RIGHT LUNG 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ABSCESSES MULTIPLE BRAIN DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS 10 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 9 , 19 59 , to March 30 , 19 59 , and the death occurred on March 30 , 19 59 , and that death occurred at 8:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH FT. HOWARD, MD 3/31/59			
ACTUAL SIGNATURE John W. Crawford		M.D. VAH FT. HOWARD, MD	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.		VAH FT. HOWARD, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-5-59	
22c. NAME OF CEMETERY OR CREMATORY Brewer-Hill		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles Hicks		24a. REC'D BY REGISTRAR APR 3 '59	
ADDRESS 45 Northwest St. Annapolis, Md		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG240 4-1-59 et

02869

2879

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX				c. LENGTH OF STAY IN 1b 2 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 116 Stemmers Run Road				d. STREET ADDRESS 116 Stemmers Run Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First REED Middle EDWARD Last SOCO		4. DATE OF DEATH Month March Day 27 Year 1959					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 26, 1906	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wheeling, W. Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Socco				14. MOTHER'S MAIDEN NAME Mary E. Platt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 233-03-1230		17. INFORMANT: Sister - Address Mrs. Florence S. Claudy 116 Stemmers Run Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of Liver						INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAR , 19 58 , to MAR , 19 59 , that I last saw the deceased alive on MAR 25 , 19 59 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Emmett P Davis M.D.				ADDRESS (Street, city or town, state) 5204 BELAIR Rd DATE SIGNED 3/27/59			
PHYSICIAN'S NAME (Type) EMMETT P DAVIS				BALTIMORE 6, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore - Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE STEWART & MOWEN CO. 108 W. North Av., Balot. #1				24a. REC'D BY REGISTRAR DATE MAR 30 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Grand	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DIET

SMOKING

ALCOHOL

DRUGS

INJURY

POISON

OTHER

REMARKS

SIGNATURE

DATE

PLACE

CAUSE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DIET

SMOKING

ALCOHOL

DRUGS

INJURY

POISON

OTHER

REMARKS

SIGNATURE

DATE

PLACE

CAUSE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

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DRUGS

INJURY

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OTHER

REMARKS

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MARRIAGE

CHILDREN

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SMOKING

ALCOHOL

DRUGS

INJURY

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REMARKS

SIGNATURE

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CAUSE

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MARRIAGE

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PREVIOUS ILLNESS

DIET

SMOKING

ALCOHOL

DRUGS

INJURY

POISON

OTHER

REMARKS

SIGNATURE

DATE

PLACE

CAUSE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DIET

SMOKING

ALCOHOL

DRUGS

INJURY

POISON

OTHER

REMARKS

SIGNATURE

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ALCOHOL

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INJURY

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REMARKS

SIGNATURE

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PLACE

CAUSE

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RELIGION

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CHILDREN

PREVIOUS ILLNESS

DIET

SMOKING

ALCOHOL

DRUGS

INJURY

POISON

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REMARKS

SIGNATURE

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PLACE

CAUSE

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SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DIET

SMOKING

ALCOHOL

DRUGS

INJURY

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REMARKS

SIGNATURE

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CAUSE

AGE

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RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DIET

SMOKING

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DRUGS

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REMARKS

SIGNATURE

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RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DIET

SMOKING

ALCOHOL

DRUGS

INJURY

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REMARKS

SIGNATURE

DATE

PLACE

CAUSE

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SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DIET

SMOKING

ALCOHOL

DRUGS

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REMARKS

SIGNATURE

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CAUSE

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EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

DIET

SMOKING

ALCOHOL

DRUGS

INJURY

POISON

OTHER

REMARKS

SIGNATURE

DATE

PLACE

CAUSE

AGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02870

CERTIFICATE OF DEATH

2880

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forest Haven Nursing Home 315 Ingleside Av.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3v01-4			
3. NAME OF DECEASED (Type or print) First Middle Last Lulie Eliza Somerville				4. DATE OF DEATH Month Day Year March 3 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1866	9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME - - - - Downey				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Mrs. Dorothy Lewis 702 Bay Street Balto 11, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PO - MURDER - SORE - DUE TO (c) PNEUMONITIS						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/1 , 19 59 , to 3/3 , 19 59 , that I last saw the deceased alive on 3/3 , 19 59 , and that death occurred at 9 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. H. M.D. 5800 S. D. M. M. 3/4/59							
ACTUAL SIGNATURE John H. H. M.D.				PHYSICIAN'S NAME (Type) John H. H. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 6, 1959		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home 3631 Falls Rd. Balto. Md. Forrest P. Burgee				24a. REC'D BY REGISTRAR DATE MAR 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. H. H.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

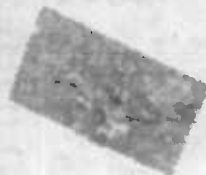
2723 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02871

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Artutur</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Artutur</u>	
c. LENGTH OF STAY in 1b <u>17 yrs.</u>		d. STREET ADDRESS <u>1203 Marden choice</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1203 Marden choice Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WARD H. SPIKER</u>		4. DATE OF DEATH <u>Mar 24 1959</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-21-1904</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>W. Maryland Martinsburg W Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur L Spiker</u>		14. MOTHER'S MAIDEN NAME <u>Ann Ruble</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-35-12-1234</u>	
17. INFORMANT <u>Esther G Spiker-Marden choice</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation by hanging with rope in garage from rafters</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>974X</u> DUE TO (c) <u>suicide</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Hanging from rafters in garage by rope</u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>6-15 3-24-59</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>garage at home Artutur Baltimore Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>G. S. M. Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>GEO. S. M. KIEFFER MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Mar 24 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		22d. LOCATION (City, town, or county) (State) <u>Martinsburg, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave.</u>	
24a. REC'D BY REGISTRAR <u>Mar 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hubbard</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF
MISSISSIPPI

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: JOHN ROBERT
 SEX: MALE AGE: 35
 DATE OF BIRTH: 1945
 PLACE OF BIRTH: MISSISSIPPI
 OCCUPATION: DRIVER
 MARITAL STATUS: SINGLE
 SOCIAL SECURITY NUMBER: 123-45-6789
 PLACE OF DEATH: HOME
 DATE OF DEATH: 1980
 TIME OF DEATH: 10:00 AM
 CAUSE OF DEATH: HEART DISEASE
 MANNER OF DEATH: NATURAL



EDUCATION: HIGH SCHOOL
 RELIGION: CHRISTIAN
 PREVIOUS ILLNESSES: None
 PREVIOUS SURGERIES: None
 PREVIOUS TRAUMAS: None
 PREVIOUS DRUGS: None
 PREVIOUS ALCOHOL: None
 PREVIOUS TOBACCO: None
 PREVIOUS OTHER: None
 PREVIOUS MEDICATIONS: None
 PREVIOUS TREATMENT: None
 PREVIOUS HOSPITALIZATION: None
 PREVIOUS PHYSICIAN: None
 PREVIOUS NURSE: None
 PREVIOUS OTHER: None

SIGNATURE OF EXAMINER: [Signature]
 TITLE: Medical Examiner
 OFFICE: State Department of Health
 ADDRESS: 1234 Main St, Jackson, MS
 PHONE: 601-123-4567
 FAX: 601-123-4567
 E-MAIL: john.robert@state.ms.gov
 WEBSITE: www.state.ms.gov
 COMMENTS: None



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02872

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. Highlands</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2824 Tennessee Ave.</u>		e. STREET ADDRESS <u>2824 Tennessee Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Jane S. Squires</u>		4. DATE OF DEATH Month <u>Mch.</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Court Reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland Balto</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James Hill</u>		14. MOTHER'S MAIDEN NAME <u>Anna L. Frisheim</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-22-0919</u>	
17. INFORMANT <u>Martha Gable</u>		Address <u>2824 Tennessee Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardio vascular disease</u> (c) <u>Senility . Malnutrition</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-31-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Int. Olmsted Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Fredrick Rd. Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Johnson</u>		24a. REC'D BY REGISTRAR <u>APR 1 '59</u>	
ADDRESS <u>2379 Wash Blvd SEB</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

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2882

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - ROCKDALE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u> 0937.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3508 ROLLING RD., BALTO. 7, MD</u>				d. STREET ADDRESS <u>WESTEND AVE</u>			
3. NAME OF DECEASED (Type or print) <u>STACK, ESTELLE EDITH</u>				4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 25, 1883</u> 75 yrs.		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NORTH</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Dail</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MRS. AGNES STACK - 3508 ROLLING RD., BALTO. 7.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X CONGESTIVE HEART FAILURE</u> DUE TO <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 YEARS</u> DUE TO (c) <u>ONE MONTH</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>FEB 2, 1959</u> , to <u>MARCH 4, 1959</u> , that I last saw the deceased alive on <u>3/2, 1959</u> , and that death occurred at <u>8:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8204 LIBERTY RD., BALTO. 7, MD</u> DATE SIGNED <u>3/4/59</u>							
ACTUAL SIGNATURE <u>Edwin L. Pierpont</u> M.D.				PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 7, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cam</u>		22d. LOCATION (City, town, or county) (State) <u>Hurlock Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service</u> ADDRESS <u>Cambridge Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>NEW YORK</i>		5. DATE OF BIRTH <i>1910</i>		6. PLACE OF DEATH <i>BALTIMORE</i>	
7. OCCUPATION <i>CLERK</i>		8. CAUSE OF DEATH <i>HEART DISEASE</i>		9. MANNER OF DEATH <i>NATURAL</i>	
10. DATE OF DEATH <i>1955</i>		11. TIME OF DEATH <i>10:00 AM</i>		12. SIGNATURE OF PHYSICIAN <i>[Signature]</i>	
13. SIGNATURE OF REGISTRAR <i>[Signature]</i>		14. SIGNATURE OF WITNESS <i>[Signature]</i>		15. SIGNATURE OF SECOND WITNESS <i>[Signature]</i>	
16. SIGNATURE OF THIRD WITNESS <i>[Signature]</i>		17. SIGNATURE OF FOURTH WITNESS <i>[Signature]</i>		18. SIGNATURE OF FIFTH WITNESS <i>[Signature]</i>	
19. SIGNATURE OF SIXTH WITNESS <i>[Signature]</i>		20. SIGNATURE OF SEVENTH WITNESS <i>[Signature]</i>		21. SIGNATURE OF EIGHTH WITNESS <i>[Signature]</i>	
22. SIGNATURE OF NINTH WITNESS <i>[Signature]</i>		23. SIGNATURE OF TENTH WITNESS <i>[Signature]</i>		24. SIGNATURE OF ELEVENTH WITNESS <i>[Signature]</i>	
25. SIGNATURE OF TWELFTH WITNESS <i>[Signature]</i>		26. SIGNATURE OF THIRTEENTH WITNESS <i>[Signature]</i>		27. SIGNATURE OF FOURTEENTH WITNESS <i>[Signature]</i>	
28. SIGNATURE OF FIFTEENTH WITNESS <i>[Signature]</i>		29. SIGNATURE OF SIXTEENTH WITNESS <i>[Signature]</i>		30. SIGNATURE OF SEVENTEENTH WITNESS <i>[Signature]</i>	
31. SIGNATURE OF EIGHTEENTH WITNESS <i>[Signature]</i>		32. SIGNATURE OF NINETEENTH WITNESS <i>[Signature]</i>		33. SIGNATURE OF TWENTIETH WITNESS <i>[Signature]</i>	
34. SIGNATURE OF TWENTY-FIRST WITNESS <i>[Signature]</i>		35. SIGNATURE OF TWENTY-SECOND WITNESS <i>[Signature]</i>		36. SIGNATURE OF TWENTY-THIRD WITNESS <i>[Signature]</i>	
37. SIGNATURE OF TWENTY-FOURTH WITNESS <i>[Signature]</i>		38. SIGNATURE OF TWENTY-FIFTH WITNESS <i>[Signature]</i>		39. SIGNATURE OF TWENTY-SIXTH WITNESS <i>[Signature]</i>	
40. SIGNATURE OF TWENTY-SEVENTH WITNESS <i>[Signature]</i>		41. SIGNATURE OF TWENTY-EIGHTH WITNESS <i>[Signature]</i>		42. SIGNATURE OF TWENTY-NINTH WITNESS <i>[Signature]</i>	
43. SIGNATURE OF THIRTIETH WITNESS <i>[Signature]</i>		44. SIGNATURE OF THIRTY-FIRST WITNESS <i>[Signature]</i>		45. SIGNATURE OF THIRTY-SECOND WITNESS <i>[Signature]</i>	
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49. SIGNATURE OF THIRTY-SIXTH WITNESS <i>[Signature]</i>		50. SIGNATURE OF THIRTY-SEVENTH WITNESS <i>[Signature]</i>		51. SIGNATURE OF THIRTY-EIGHTH WITNESS <i>[Signature]</i>	
52. SIGNATURE OF THIRTY-NINTH WITNESS <i>[Signature]</i>		53. SIGNATURE OF FORTY WITNESS <i>[Signature]</i>		54. SIGNATURE OF FORTY-FIRST WITNESS <i>[Signature]</i>	
55. SIGNATURE OF FORTY-SECOND WITNESS <i>[Signature]</i>		56. SIGNATURE OF FORTY-THIRD WITNESS <i>[Signature]</i>		57. SIGNATURE OF FORTY-FOURTH WITNESS <i>[Signature]</i>	
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61. SIGNATURE OF FORTY-EIGHTH WITNESS <i>[Signature]</i>		62. SIGNATURE OF FORTY-NINTH WITNESS <i>[Signature]</i>		63. SIGNATURE OF FIFTIETH WITNESS <i>[Signature]</i>	
64. SIGNATURE OF FIFTY-FIRST WITNESS <i>[Signature]</i>		65. SIGNATURE OF FIFTY-SECOND WITNESS <i>[Signature]</i>		66. SIGNATURE OF FIFTY-THIRD WITNESS <i>[Signature]</i>	
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70. SIGNATURE OF FIFTY-SEVENTH WITNESS <i>[Signature]</i>		71. SIGNATURE OF FIFTY-EIGHTH WITNESS <i>[Signature]</i>		72. SIGNATURE OF FIFTY-NINTH WITNESS <i>[Signature]</i>	
73. SIGNATURE OF SIXTIETH WITNESS <i>[Signature]</i>		74. SIGNATURE OF SIXTY-FIRST WITNESS <i>[Signature]</i>		75. SIGNATURE OF SIXTY-SECOND WITNESS <i>[Signature]</i>	
76. SIGNATURE OF SIXTY-THIRD WITNESS <i>[Signature]</i>		77. SIGNATURE OF SIXTY-FOURTH WITNESS <i>[Signature]</i>		78. SIGNATURE OF SIXTY-FIFTH WITNESS <i>[Signature]</i>	
79. SIGNATURE OF SIXTY-SIXTH WITNESS <i>[Signature]</i>		80. SIGNATURE OF SIXTY-SEVENTH WITNESS <i>[Signature]</i>		81. SIGNATURE OF SIXTY-EIGHTH WITNESS <i>[Signature]</i>	
82. SIGNATURE OF SIXTY-NINTH WITNESS <i>[Signature]</i>		83. SIGNATURE OF SIXTY-TENTH WITNESS <i>[Signature]</i>		84. SIGNATURE OF SIXTY-ONE WITNESS <i>[Signature]</i>	
85. SIGNATURE OF SIXTY-TWO WITNESS <i>[Signature]</i>		86. SIGNATURE OF SIXTY-THREE WITNESS <i>[Signature]</i>		87. SIGNATURE OF SIXTY-FOUR WITNESS <i>[Signature]</i>	
88. SIGNATURE OF SIXTY-FIVE WITNESS <i>[Signature]</i>		89. SIGNATURE OF SIXTY-SIX WITNESS <i>[Signature]</i>		90. SIGNATURE OF SIXTY-SEVEN WITNESS <i>[Signature]</i>	
91. SIGNATURE OF SIXTY-EIGHT WITNESS <i>[Signature]</i>		92. SIGNATURE OF SIXTY-NINE WITNESS <i>[Signature]</i>		93. SIGNATURE OF SEVENTY WITNESS <i>[Signature]</i>	
94. SIGNATURE OF SEVENTY-ONE WITNESS <i>[Signature]</i>		95. SIGNATURE OF SEVENTY-TWO WITNESS <i>[Signature]</i>		96. SIGNATURE OF SEVENTY-THREE WITNESS <i>[Signature]</i>	
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100. SIGNATURE OF SEVENTY-SEVEN WITNESS <i>[Signature]</i>		101. SIGNATURE OF SEVENTY-EIGHT WITNESS <i>[Signature]</i>		102. SIGNATURE OF SEVENTY-NINE WITNESS <i>[Signature]</i>	
103. SIGNATURE OF EIGHTY WITNESS <i>[Signature]</i>		104. SIGNATURE OF EIGHTY-ONE WITNESS <i>[Signature]</i>		105. SIGNATURE OF EIGHTY-TWO WITNESS <i>[Signature]</i>	
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109. SIGNATURE OF EIGHTY-SIX WITNESS <i>[Signature]</i>		110. SIGNATURE OF EIGHTY-SEVEN WITNESS <i>[Signature]</i>		111. SIGNATURE OF EIGHTY-EIGHT WITNESS <i>[Signature]</i>	
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115. SIGNATURE OF NINETY-TWO WITNESS <i>[Signature]</i>		116. SIGNATURE OF NINETY-THREE WITNESS <i>[Signature]</i>		117. SIGNATURE OF NINETY-FOUR WITNESS <i>[Signature]</i>	
118. SIGNATURE OF NINETY-FIVE WITNESS <i>[Signature]</i>		119. SIGNATURE OF NINETY-SIX WITNESS <i>[Signature]</i>		120. SIGNATURE OF NINETY-SEVEN WITNESS <i>[Signature]</i>	
121. SIGNATURE OF NINETY-EIGHT WITNESS <i>[Signature]</i>		122. SIGNATURE OF NINETY-NINE WITNESS <i>[Signature]</i>		123. SIGNATURE OF HUNDRED WITNESS <i>[Signature]</i>	

1. NAME OF DECEASED
2. SEX
3. AGE
4. PLACE OF BIRTH
5. DATE OF BIRTH
6. PLACE OF DEATH
7. OCCUPATION
8. CAUSE OF DEATH
9. MANNER OF DEATH
10. DATE OF DEATH
11. TIME OF DEATH
12. SIGNATURE OF PHYSICIAN
13. SIGNATURE OF REGISTRAR
14. SIGNATURE OF WITNESS
15. SIGNATURE OF SECOND WITNESS
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121. SIGNATURE OF NINETY-EIGHT WITNESS
122. SIGNATURE OF NINETY-NINE WITNESS
123. SIGNATURE OF HUNDRED WITNESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2883

CERTIFICATE OF DEATH

02874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE 109 Monterey Ave b. COUNTY Ad ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton Maryland 02x-2	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) EVA First Middle Last STEARNS		4. DATE OF DEATH Month March Day 24 Year 1919	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 17 1900
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Albert Biel		14. MOTHER'S MAIDEN NAME Amanda Bender	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Personal History Address Hospital Records, Eudowood Sanatorium			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic Carcinoma Lung 180x DUE TO Probably from adenocarcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Kidney DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 17 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1918 , to March 24, 1919 , that I last saw the deceased alive on March 24, 1919 , and that death occurred at 1:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Milton B. Kress M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Milton B. Kress, M.D.		Eudowood Sanatorium, Towson 4, Md.	
22a. BURIAL, CREMATION, or other disposition (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
cremation	3/26/59	Green Mount	Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Pl.		24a. REC'D BY REGISTRAR MAR 30 59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kress	

CERTIFICATE OF DEATH

1922

PLACE OF DEATH

MARYLAND

DATE OF DEATH

1922

SEX

MALE

AGE

100

CAUSE OF DEATH

HEART DISEASE

PLACE OF BIRTH

MARYLAND

DATE OF BIRTH

1822

PLACE OF DEATH

MARYLAND

DATE OF DEATH

1922

SEX

MALE

AGE

100

CAUSE OF DEATH

HEART DISEASE

PLACE OF BIRTH

MARYLAND

DATE OF BIRTH

1822

PLACE OF DEATH

MARYLAND

DATE OF DEATH

1922

SEX

MALE

AGE

100

CAUSE OF DEATH

HEART DISEASE

PLACE OF BIRTH

MARYLAND

DATE OF BIRTH

1822

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02875

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 Padonia Rd.		d. STREET ADDRESS 101 Padonia Rd.	
3. NAME OF DECEASED (Type or print) First George Middle Franklin Last Stephenson		4. DATE OF DEATH Month March Day 13 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1870
9. AGE (In years and birthday) 88 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin N, Stephenson		14. MOTHER'S MAIDEN NAME Nancy Jane Schnover	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Frederick L. Stephenson		Address 3932 Lyndale Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 Days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 1957 to March 13, 1959 , that I last saw the deceased alive on March 10, 1959 , and that death occurred at 4:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7501 York Rd Baltimore DATE SIGNED 3/14/59 ACTUAL SIGNATURE Charles F O'Donnell M.D. PHYSICIAN'S NAME (Type) Charles F O'Donnell			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/59	
22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gar.		22d. LOCATION (City, town, or county) (State) York Rd Baltimore County.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.		ADDRESS 1050 York Rd.	
24a. REC'D BY REGISTRAR DATE MAR 16 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

1. NAME OF DECEASED George Washington		2. SEX Male		3. AGE 65	
4. DATE OF DEATH Jan 15, 1910		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Coronary Artery Disease		9. PRESENT ILLNESS Angina Pectoris	
10. OCCASION OF DEATH Natural		11. PLACE OF BIRTH Maryland		12. DATE OF BIRTH Jan 1, 1845	
13. NAME OF FATHER John Washington		14. NAME OF MOTHER Mary Washington		15. NAME OF SPOUSE Elizabeth Washington	
16. NAME OF REGISTRAR John Washington		17. SIGNATURE OF REGISTRAR [Signature]		18. NAME OF PHYSICIAN Dr. John Washington	
19. SIGNATURE OF PHYSICIAN [Signature]		20. NAME OF CLERK John Washington		21. SIGNATURE OF CLERK [Signature]	
22. NAME OF CHURCH St. John's Church		23. NAME OF MINISTER Rev. John Washington		24. NAME OF FUNERAL HOME John Washington	
25. NAME OF BURIAL PLACE St. John's Cemetery		26. NAME OF INTERMENT John Washington		27. NAME OF CEMETERY St. John's Cemetery	
28. NAME OF CEMETERY St. John's Cemetery		29. NAME OF CEMETERY St. John's Cemetery		30. NAME OF CEMETERY St. John's Cemetery	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02876

Reg. Dist. No.

2885

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE Md. b. COUNTY Balt.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) Towson Convelesent Home		d. STREET ADDRESS 120 Greenbrier Road	
3. NAME OF DECEASED (Type or print) First Marguerits Middle Thompson Last Stewart		4. DATE OF DEATH Month March Day 17, Year 59	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired hostess Dept. Store dining room		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) N. C.
13. FATHER'S NAME Herbert Thompson		14. MOTHER'S MAIDEN NAME Cecelia Covington	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address Towson, Md. Mrs. Cecelia S. Chandler 120 Greenbrier Rd.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Broncho 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized (arteriovascular + cardiac) arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June , 19 55 , to 17 Mar , 19 59 , that I last saw the deceased alive on 27 Mar , 19 59 , and that death occurred at 6:35 PM , from the causes and on the date stated above.		
ACTUAL SIGNATURE John B. DeHoff M.D.		DATE SIGNED 2020 N. Charles St. Balt 012
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 19, 1959	22c. NAME OF CEMETERY OR CREMATORY Lorraine
22d. LOCATION (City, town, or county) Baltimore, (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Pl. ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 20 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

02838

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH March 15, 1892		5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Carpenter	
7. DECEASED AT Baltimore, Md.		8. DATE OF DEATH March 25, 1958		9. TIME OF DEATH 10:30 AM		10. PLACE OF DEATH Home		11. CAUSE OF DEATH Myocardial Infarction		12. MANNER OF DEATH Natural	
13. SIGNATURE OF DECEASED James H. Harris		14. SIGNATURE OF WITNESS John J. Harris		15. SIGNATURE OF DECEASED'S NEAREST RELATIVE Mary H. Harris		16. SIGNATURE OF DECEASED'S PHYSICIAN Dr. J. H. Harris		17. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. J. H. Harris		18. SIGNATURE OF DECEASED'S BURIAL OFFICER John J. Harris	
19. SIGNATURE OF DECEASED'S FUNERAL HOME John J. Harris		20. SIGNATURE OF DECEASED'S BURIAL OFFICER John J. Harris		21. SIGNATURE OF DECEASED'S BURIAL OFFICER John J. Harris		22. SIGNATURE OF DECEASED'S BURIAL OFFICER John J. Harris		23. SIGNATURE OF DECEASED'S BURIAL OFFICER John J. Harris		24. SIGNATURE OF DECEASED'S BURIAL OFFICER John J. Harris	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2886

CERTIFICATE OF DEATH

02877

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>York Rd</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Lida K. Stocksdale</u>		4. DATE OF DEATH Month Day Year <u>March 10 19 59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10, 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13. FATHER'S NAME <u>Wm F. Kauffman</u>	14. MOTHER'S MAIDEN NAME <u>Elizabeth Carroll</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>Otis Stocksdale, Parkton, Md.</u> Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar. 7, 1957, to Mar. 10, 1959, that I last saw the deceased alive on Mar. 10, 1959, and that death occurred at 7:55 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE <u>A. M. France</u> M.D.	DATE SIGNED <u>3/11/59</u>
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PHYSICIAN'S NAME (Type) <u>Dr. A. M. France</u>	<u>Parkton, Md.</u>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 12 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Maryland Line Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Maryland Line Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u> ADDRESS <u>New Freedom, Pa.</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>

DATE MAR 12 '59

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		CAUSE OF DEATH	
1. CITY OR TOWN		1. DISEASE	
2. COUNTY		2. PLACE OF DEATH	
3. DISTRICT		3. DATE OF DEATH	
4. SEX		4. AGE	
5. COLOR		5. OCCUPATION	
6. MARITAL STATUS		6. EDUCATION	
7. RELIGION		7. SERVICE	
8. PLACE OF BIRTH		8. PLACE OF DEATH	
9. DATE OF BIRTH		9. DATE OF DEATH	
10. TIME OF DEATH		10. TIME OF DEATH	
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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

2887

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Presbyterian Home of Maryland				d. STREET ADDRESS 12X-2			
3. NAME OF DECEASED (Type or print) Julia D. Stokes				4. DATE OF DEATH March 31, 1959			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19, 1878	
				9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME James Franklin Devoe				14. MOTHER'S MAIDEN NAME Eliza G. Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Records of Presbyterian Home Address Towson 4, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO a coronary occlusion with myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardiovascular disease DUE TO years (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from JAN 1 , 19 58 , to MAR 31 , 19 59 , that I last saw the deceased alive on MARCH 31 , 19 59 , and that death occurred at 3:35 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7215 York Rd Baltimore 12 Maryland DATE SIGNED							
ACTUAL SIGNATURE A. Venable Jr				M.D. S. J. VENABLE, JR			
PHYSICIAN'S NAME (Type) S. J. VENABLE, JR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 3, 1959		22c. NAME OF CEMETERY OR CREMATORY Bethal		22d. LOCATION (City, town, or county) (State) Madonna, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc. 1900 Eutaw Place ADDRESS				24a. REC'D BY REGISTRAR APR 3 '59 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G242 5-6-59 et

2888

CERTIFICATE OF DEATH

02879

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove St. Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ann Margaret Stone</u> First <u>Ann</u> Middle <u>M.</u> Last <u>Stone</u>		DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-71</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>26</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Mask</u>		14. MOTHER'S MAIDEN NAME <u>Julien Fuller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Joseph Mask brother</u>	
17. INFORMANT <u>Joseph Mask brother</u> Address <u></u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-12</u> , 19 <u>59</u> , to <u>3-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-26</u> , 19 <u>59</u> , and that death occurred at <u>8:30</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachsler</u> M.D.		ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL</u> DATE SIGNED <u>3-27-59</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Dir. 4101 Edmondson Ave.</u>		24a. REC'D BY REGISTRAR <u>MAR 30 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER OF THE GOSPEL		17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF CREMATION	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
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100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middle River		c. LENGTH OF STAY IN 1b 6 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3v01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hall Nursing Home		d. STREET ADDRESS 809 N. Luzerne Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last (James-Jerry) Jaroslav A. Svejda		4. DATE OF DEATH Month Day Year March 10 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/1877
9. AGE (In years less birthday) yrs. 81		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ret-Mechanical Engineer -U.S.Govt.		10b. KIND OF BUSINESS OR INDUSTRY Austria	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Norbert Svejda, son, 5919 Eurith Ave. 6			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic Cardio Vascular Disease DUE TO (c) 3 yrs INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1 , 19 57 , to March 9 , 19 59 , that I last saw the deceased alive on March 9 , 19 59 , and that death occurred at 6 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Baumgardner M.D.		ADDRESS (Street, city or town, state) Balto 6 Md	
PHYSICIAN'S NAME (Type)		DATE SIGNED 3/11/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/14/59	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		ADDRESS Funeral Home 3331 Brehms Lane	
24a. REGISTRY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Anthony J. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45	
4. DATE OF DEATH March 10, 1957		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Salesman		11. EDUCATION High School		12. RELIGION Roman Catholic	
13. MARITAL STATUS Married		14. DATE OF MARRIAGE 1935		15. NAME OF SPOUSE Mary Harris	
16. NAME OF PHYSICIAN Dr. J. H. Harris		17. NAME OF HOSPITAL None		18. NAME OF NURSE None	
19. NAME OF CORONER J. H. Harris		20. NAME OF BURIAL PLACE St. Mary's Cemetery		21. NAME OF MINISTER Rev. J. H. Harris	
22. NAME OF FUNERAL HOME J. H. Harris		23. NAME OF CEMETERY St. Mary's Cemetery		24. NAME OF INTERMENT St. Mary's Cemetery	
25. NAME OF DECEASED'S NEXT OF KIN J. H. Harris		26. NAME OF DECEASED'S NEXT OF KIN J. H. Harris		27. NAME OF DECEASED'S NEXT OF KIN J. H. Harris	
28. NAME OF DECEASED'S NEXT OF KIN J. H. Harris		29. NAME OF DECEASED'S NEXT OF KIN J. H. Harris		30. NAME OF DECEASED'S NEXT OF KIN J. H. Harris	
31. NAME OF DECEASED'S NEXT OF KIN J. H. Harris		32. NAME OF DECEASED'S NEXT OF KIN J. H. Harris		33. NAME OF DECEASED'S NEXT OF KIN J. H. Harris	
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1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF DEATH
5. TIME OF DEATH
6. PLACE OF DEATH
7. CAUSE OF DEATH
8. MANNER OF DEATH
9. PLACE OF BIRTH
10. OCCUPATION
11. EDUCATION
12. RELIGION
13. MARITAL STATUS
14. DATE OF MARRIAGE
15. NAME OF SPOUSE
16. NAME OF PHYSICIAN
17. NAME OF HOSPITAL
18. NAME OF NURSE
19. NAME OF CORONER
20. NAME OF BURIAL PLACE
21. NAME OF MINISTER
22. NAME OF FUNERAL HOME
23. NAME OF CEMETERY
24. NAME OF INTERMENT
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CERTIFICATE OF DEATH

2890

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 99 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		(2) 3 YOI-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 646 West Saratoga Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LA VAUGHN		First Middle Last --- SWANSON		4. DATE OF DEATH Month Day Year March 10 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22, 1914	
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper - Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucker		11. BIRTHPLACE (State or foreign country) Anniston, Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Allen Swanson				14. MOTHER'S MAIDEN NAME Mary Blackman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 217-07-2303		17. INFORMANT Address Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, RIGHT PYRIFORM FOSSA; TUMOR METASTASES 147X XXXXXX TO CERVICAL LYMPH NODES AND RIGHT LUNG Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 1, 1958 , to March 10, 1959 , that I took care of the deceased and that death occurred at 4:10 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Donald D. Mark M.D. VAH, FT. HOWARD, MD. 3/11/59 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D. VAH, FORT HOWARD, MARYLAND 3/11/59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/13/59		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Arlington S. Phillips, Baltimore 17, Md.				24a. REC'D BY REGISTRAR DATE MAR 19 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2200

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1925

DATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

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2891

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>				c. LENGTH OF STAY IN 1b <i>55</i> <i>Towson</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1705 Aberdeen Road</i>				d. STREET ADDRESS <i>1705 Aberdeen Road</i>			
e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Mr. Christopher West Tabb, Sr.</i>				4. DATE OF DEATH <i>March 6th</i> 19 <i>59</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr. 3, 1879</i>	
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Postal Clerk</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>William K. Tabb</i>				14. MOTHER'S MAIDEN NAME <i>Martha Jane</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Ella Mae Tabb, 1705 Aberdeen Road.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial</i> <i>422.1</i> DUE TO <i>Arterio-sclerotic C U</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Dissect</i> (c) <i>Dissect</i>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 12</i> 19 <i>59</i> to <i>Mar 6</i> 19 <i>59</i> , that I last saw the deceased alive on <i>Mar 6</i> 19 <i>59</i> , and that death occurred at <i>4:45 p.m.</i> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>3033 W North A</i> DATE SIGNED <i>Baltimore MD</i>			
ACTUAL SIGNATURE <i>M Paul Byerly</i> M.D.							
PHYSICIAN'S NAME (Type) <i>M Paul Byerly</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/10/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>				24a. REC'D BY REGISTRAR <i>MAR 10 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02883

2892

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>50 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Lutherville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1436 Bellona Ave</u>				d. STREET ADDRESS <u>1436 Bellona Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Addie</u> Middle <u>Boyd</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1889</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>Chase City, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unk.</u>				14. MOTHER'S MAIDEN NAME <u>unk.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Zelle Johnson</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u> <u>Same years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 15, 1959</u> to <u>March 16, 1959</u> , that I last saw the deceased alive on <u>March 15, 1959</u> , and that death occurred at <u>4:20 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter T. Kees</u>				ADDRESS (Street, city or town, state) <u>Cockeysville Md</u>			
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>				DATE SIGNED <u>March 16, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>March 20, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>		22d. LOCATION (City, town, or county) (State) <u>Towson, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William E. ...</u>				ADDRESS <u>1431 ...</u>		24a. REC'D BY REGISTRAR <u>MAR 17 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13,14 FilmG240 3-30-59 et

CERTIFICATE OF DEATH

02884

Reg. Dist. No.

2893

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				c. LENGTH OF STAY IN 1b 16 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home - Painters Mill Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILBERT DORSEY Middle TAYLOR Last				4. DATE OF DEATH Month 3 Day 26 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 6. 1878	
9. AGE (In years last birthday) 80 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Dorsey Taylor			
14. MOTHER'S MAIDEN NAME Lisa Bell				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. NONE				17. INFORMANT Son-in-law Address Mill			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Granuloma Fungoides DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 205x DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mild virus infection				INTERVAL BETWEEN ONSET AND DEATH 8 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 May , 19 58 , to 26 March , 19 59 , that I last saw the deceased alive on 25 March , 19 59 , and that death occurred at 9:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 802 Cathedral Street DATE SIGNED							
ACTUAL SIGNATURE J. Douglas Lockard M.D.				802 Cathedral Street			
PHYSICIAN'S NAME (Type) J. Douglas Lockard M.D.				Baltimore 1, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 28, 1959		22c. NAME OF CEMETERY OR CREMATORY Pine Grove Cemetery		22d. LOCATION (City, town, or county) (State) Rayville, Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE STEWART & MOWEN COMPANY - 108 W. North Av.-				ADDRESS Balto.		24a. REC'D BY REGISTRAR MAR 30 '59	
				24b. REGISTRAR'S SIGNATURE Wm S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF BIRTH		PLACE OF DEATH		CITY		COUNTY		STATE	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT		CORONER	
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM		BURIAL	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Likesville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If in hospital, give street address) <u>1319 Glade Ave</u>		d. STREET ADDRESS <u>4300 Liberty Heights Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Jennie Thaler</u>		4. DATE OF DEATH <u>3-31-1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>
13. FATHER'S NAME <u>Joseph Schwaber</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of left breast.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>20 mo.</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1956</u> , to <u>3/31/1959</u> , that I last saw the deceased alive on <u>3/31/1959</u> , and that death occurred at <u>11:29</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. A. Silver</u>		ADDRESS (Street, city or town, state) <u>Tough goods APT. 4/1/59</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>A. A. SILVER. M.D.</u>		<u>Baltimore, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4-2-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewicki</u> ADDRESS <u>2100 Eutan Place</u>		24a. REC'D BY REGISTRAR DATE <u>APR 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Homan</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director's pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Lithuania" and "Lithuanian" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02886

CERTIFICATE OF DEATH

Reg. Dist. No.

2895

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 30 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle THOMAS Last		4. DATE OF DEATH Month March Day 26 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1886
9. AGE (In years lost birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10b. KIND OF BUSINESS OR INDUSTRY Paper Mfg Co.		11. BIRTHPLACE (State or foreign country) St. Marys Co., Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME James Thomas	
14. MOTHER'S MAIDEN NAME Charlotte (Unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I	
16. SOCIAL SECURITY NO. 218-01-1791		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft Howard, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332 x IMMEDIATE CAUSE (a) LEFT CEREBRAL THROMBOSIS WITH RIGHT HEMIPARESIS DUE TO CEREBRAL ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus; Hypertensive Cardiovascular disease 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 24, 19 59, to March 26, 19 59 , and that death occurred at 12:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3/26/59			
ACTUAL SIGNATURE John W. Crawford M.D. VAH Ft. Howard, Md		PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D. VAH Ft Howard, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-31-59	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Rayner Sanders 217 E. Preston St. Balto. Md		24a. REC'D BY REGISTRAR APR 2 '59	
24b. REGISTRAR'S SIGNATURE Charles E. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

Name of deceased		Sex		Age		Date of death		Place of death	
John Doe		Male		45		Jan 15, 1922		Home	
Cause of death		Disease		Symptoms		Time of death		Physician	
Heart failure		Myocardial infarction		Chest pain, shortness of breath		10:30 AM		Dr. J. Smith	
Occupation		Education		Marital status		Religion		Burial place	
Teacher		High School		Married		Catholic		St. Mary's Church	
Signature of physician		Signature of registrar		Signature of informant		Signature of witness		Signature of undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of certificate		Place of certificate		Name of registrar		Name of informant		Name of witness	
Jan 16, 1922		Baltimore		John Doe		John Doe		John Doe	

2896

CERTIFICATE OF DEATH

02887

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY 01-02-2 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 318 FAYETTE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EUGENIE Middle CLARA Last THRUSH		4. DATE OF DEATH Month MARCH Day 31 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-24 9. AGE (In years last birthday) 34 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) LEWISTOWN, PA. 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME GEORGE A. THRUSH		14. MOTHER'S MAIDEN NAME DOROTHY BLACK (DEAD)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ROSEWOOD RECORDS 17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic pneumonia and DUE TO aspiration of blood (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that, I attended the deceased from 9-13-35 to 3-31 , 19 59 , that I last saw the deceased alive on 3-31 , 19 59 , and that death occurred at 9:50 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter W. Rieckert		ADDRESS (Street, city or town, state) 4307 Mainfield Ave Baltimore 14 DATE SIGNED 4/14	
PHYSICIAN'S NAME (Type) Peter W. Rieckert			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 2/59	22c. NAME OF CEMETERY OR CREMATORY St. Marks	22d. LOCATION (City, town, or county) (State) Lewistown, Millin Co. Pa.
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE APR 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Thoma

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Form with multiple sections for recording death information, including fields for name, age, sex, date of death, cause of death, and place of death. The form is divided into several horizontal sections with labels for each field.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02888

2897

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>26 yrs</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Tomczak</u> Last <u>Tomczak</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1959</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 15, 1899</u>			
9. AGE (In years and birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>14</u> Hours <u>14</u> Min.		IF UNDER 24 HRS. Months <u>24</u> Days <u>14</u> Hours <u>14</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>					
11. BIRTHPLACE (State or foreign country) <u>Poland</u>				12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>					
13. FATHER'S NAME <u>John Tomczak</u>				14. MOTHER'S MAIDEN NAME <u>Julia Kostek</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>					
17. INFORMANT <u>Hospital records</u>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO <u>25 yrs</u> (c)								INTERVAL BETWEEN ONSET AND DEATH <u>12 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> to <u>March</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 7</u> , 19 <u>59</u> , and that death occurred at <u>12:30 A</u> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>James Donald Drinkard</u>				ADDRESS (Street, city or town, state) <u>Spring Grove</u>					
PHYSICIAN'S NAME (Type) <u>James Donald Drinkard</u>				DATE SIGNED <u>3-7-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>George A Weber</u>				ADDRESS <u>705 S Ann st</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 9 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. [illegible]</u>									

CERTIFICATE OF DEATH

File No. 10

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Place of birth: <u>NEW YORK</u></p>	
<p>5. Date of death: <u>1975</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Date of filing: <u>1975</u></p>		<p>12. File number: <u>10</u></p>	

Office of the Registrar

State Department of Health

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2898

CERTIFICATE OF DEATH

Reg. Dist. No.

02889

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland c. LENGTH OF STAY IN 1b 3Y01-4 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY d. STREET ADDRESS 315 E. NORTH AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS HENRY TRACEY		4. DATE OF DEATH Month Day Year MARCH 11 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LOCOMOTIVE ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY RAILWAY	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME CHARLES M. TRACEY		14. MOTHER'S MAIDEN NAME CLARA E. GORDON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH Uncertain	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 10, 1959 , to MARCH 11, 1959 , that I last saw the deceased alive on MARCH 11, 1959 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED _____			
ACTUAL SIGNATURE William Newcomer		M.D. Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-14-59	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Woodlawn, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc.		24a. REC'D BY REGISTRAR DATE MAR 13 '59	
ADDRESS St. Paul & Preston St.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

100

2899

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 60 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle H. Last TUCKER		4. DATE OF DEATH Month March Day 3 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/95
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Navy Yard	11. BIRTHPLACE (State or foreign country) Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Tucker	
14. MOTHER'S MAIDEN NAME Victoria Hammon		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW I	
16. SOCIAL SECURITY NO. 215-10-0560		17. INFORMANT Clin. Records, VA Hosp., Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA RIGHT LUNG WITH METASTASIS 162.1 TO BRAIN AND ADRENALS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from January 2 , 19 59 , to March 3 , 19 59 , and that death occurred at 5:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VA Hospital, Ft. Howard, Md. DATE SIGNED ACTUAL SIGNATURE Chien Wei Ian M.D. VA Hospital, Ft. Howard, Md. PHYSICIAN'S NAME (Type) CH IEN WEI IAN VA Hospital, Ft. Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 8, 1959	22c. NAME OF CEMETERY OR CREMATORY Asbury Meth. Chruch Cemetery Broadneck, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson Funeral Home, 1000 Brantley Ave.		24a. REC'D BY REGISTRAR MAR 10 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

2900

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		e. STREET ADDRESS 224 N. Monroe Street	
3. NAME OF DECEASED (Type or print) CHARLES FREDERICK UHLENBERG		4. DATE OF DEATH Month March Day 20 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1868
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman F. Uhlenberg		14. MOTHER'S MAIDEN NAME Mary E. Brockhagen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT C. Edward Hoerichs - 424 Academy Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cronary Thrombosis 420.1 DUE TO Cardio-Vascular Disease & Gradual Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Deconensation DUE TO (c) 10 Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/8 , 19 59 , to 3/20 , 19 59 , that I last saw the deceased alive on 3/20 , 19 59 , and that death occurred at 4:58 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Eliot W. Johnson M.D.		ADDRESS (Street, city or town, state) 34 32 Frederick Ave Baltimore DATE SIGNED 3/27/59	
PHYSICIAN'S NAME (Type) ELIOT W. JOHNSON MD. Baltimore 29 Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/1959	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost Ellsworth Armacost-4600 Liberty Hgts. Ave.		24a. REC'D BY REGISTRAR MAR 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Birth: Jan 1, 1925

5. Date of Death: Dec 1, 1970

6. Place of Birth: USA

7. Usual Residence: 123 Main St, Baltimore, MD

8. Cause of Death: Heart Disease

9. Manner of Death: Natural

10. Signature of Physician: [Signature]

11. Signature of Registrar: [Signature]

12. Date of Registration: Dec 1, 1970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02892

2901

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8001 York Road				d. STREET ADDRESS 8001 York Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CAROLINE Middle VANDERMAST Last VANDERMAST				4. DATE OF DEATH Month March Day 22 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1892	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.		IF UNDER 24 HRS. Months 66 Days 66 Hours 66 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Ernest William Vandermast				14. MOTHER'S MAIDEN NAME Emma Christine Schaaake			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Adolph Vandermast - 8001 York Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung (secondary) 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the uterus DUE TO (c) abdominal metastases				INTERVAL BETWEEN ONSET AND DEATH 2 mos. Indefinite			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 15, 19 58 , to Dec 22, 19 59 , that I last saw the deceased alive on Dec 20th, 19 59 , and that death occurred at 10:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Nathaniel M. Beck				ADDRESS (Street, city or town, state) 2818 St Paul St Baltimore DATE SIGNED #181MD			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 26, 1959		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC. ADDRESS Balto., Md.				24a. REC'D BY REGISTRAR MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

CERTIFICATE OF DEATH

2201

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

12345678

12345678

NAME OF DECEASED JAMES W. BROWN		DATE OF DEATH 12-15-1912	
AGE 45		SEX Male	
BIRTH DATE 12-15-1867		BIRTH PLACE Boston, Mass.	
OCCUPATION Carpenter		CAUSE OF DEATH Heart Disease	
PLACE OF DEATH Home		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED James W. Brown		SIGNATURE OF WITNESS John Doe	
DATE OF SIGNATURE 12-15-1912		DATE OF SIGNATURE 12-15-1912	
PLACE OF SIGNATURE Home		PLACE OF SIGNATURE Home	
SIGNATURE OF PHYSICIAN Dr. John Doe		SIGNATURE OF CLERK John Doe	
DATE OF SIGNATURE 12-15-1912		DATE OF SIGNATURE 12-15-1912	
PLACE OF SIGNATURE Home		PLACE OF SIGNATURE Home	
SIGNATURE OF REGISTRAR John Doe		SIGNATURE OF CLERK John Doe	
DATE OF SIGNATURE 12-15-1912		DATE OF SIGNATURE 12-15-1912	
PLACE OF SIGNATURE Home		PLACE OF SIGNATURE Home	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethroe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore County</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3604 Washington Blvd.</u>		d. STREET ADDRESS <u>3604 Washington Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>A</u> Last <u>Wagener</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-1883</u>
9. AGE (In years last birthday) yrs. <u>76</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (State or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry Wagener</u>	
14. MOTHER'S MAIDEN NAME <u>Wagner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>220-22-8113</u>		17. INFORMANT <u>Henry J. Wagener - 2007 Hollins St Balto Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency -</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chr. myocardiitis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>140</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 13, 1959</u> , to <u>Mar 30, 1959</u> , that I last saw the deceased alive on <u>Mar 29, 1959</u> , and that death occurred at <u>934 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frederic V. Beidler</u>		M.D. <u>1014 Francis Ave - Balto 27 - Md.</u>	
PHYSICIAN'S NAME (Type) <u>FREDERIC V. BEIDLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 2, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington Blvd. Elkridge, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. Kenny, Inc</u>		24a. REC'D BY REGISTRAR <u>APR 1 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Charles J. Kenny</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE DAY OF

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. DATE OF DEATH</p>	
<p>13. PLACE OF DEATH</p>		<p>14. TIME OF DEATH</p>	
<p>15. SIGNATURE OF WITNESS</p>		<p>16. SIGNATURE OF DECEASED</p>	
<p>17. SIGNATURE OF NEXT OF KIN</p>		<p>18. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>19. SIGNATURE OF FUNERAL HOME</p>		<p>20. SIGNATURE OF CHURCH</p>	
<p>21. SIGNATURE OF CEMETERY</p>		<p>22. SIGNATURE OF INTERVIEWER</p>	
<p>23. SIGNATURE OF INTERVIEWER</p>		<p>24. SIGNATURE OF INTERVIEWER</p>	
<p>25. SIGNATURE OF INTERVIEWER</p>		<p>26. SIGNATURE OF INTERVIEWER</p>	
<p>27. SIGNATURE OF INTERVIEWER</p>		<p>28. SIGNATURE OF INTERVIEWER</p>	
<p>29. SIGNATURE OF INTERVIEWER</p>		<p>30. SIGNATURE OF INTERVIEWER</p>	
<p>31. SIGNATURE OF INTERVIEWER</p>		<p>32. SIGNATURE OF INTERVIEWER</p>	
<p>33. SIGNATURE OF INTERVIEWER</p>		<p>34. SIGNATURE OF INTERVIEWER</p>	
<p>35. SIGNATURE OF INTERVIEWER</p>		<p>36. SIGNATURE OF INTERVIEWER</p>	
<p>37. SIGNATURE OF INTERVIEWER</p>		<p>38. SIGNATURE OF INTERVIEWER</p>	
<p>39. SIGNATURE OF INTERVIEWER</p>		<p>40. SIGNATURE OF INTERVIEWER</p>	
<p>41. SIGNATURE OF INTERVIEWER</p>		<p>42. SIGNATURE OF INTERVIEWER</p>	
<p>43. SIGNATURE OF INTERVIEWER</p>		<p>44. SIGNATURE OF INTERVIEWER</p>	
<p>45. SIGNATURE OF INTERVIEWER</p>		<p>46. SIGNATURE OF INTERVIEWER</p>	
<p>47. SIGNATURE OF INTERVIEWER</p>		<p>48. SIGNATURE OF INTERVIEWER</p>	
<p>49. SIGNATURE OF INTERVIEWER</p>		<p>50. SIGNATURE OF INTERVIEWER</p>	
<p>51. SIGNATURE OF INTERVIEWER</p>		<p>52. SIGNATURE OF INTERVIEWER</p>	
<p>53. SIGNATURE OF INTERVIEWER</p>		<p>54. SIGNATURE OF INTERVIEWER</p>	
<p>55. SIGNATURE OF INTERVIEWER</p>		<p>56. SIGNATURE OF INTERVIEWER</p>	
<p>57. SIGNATURE OF INTERVIEWER</p>		<p>58. SIGNATURE OF INTERVIEWER</p>	
<p>59. SIGNATURE OF INTERVIEWER</p>		<p>60. SIGNATURE OF INTERVIEWER</p>	
<p>61. SIGNATURE OF INTERVIEWER</p>		<p>62. SIGNATURE OF INTERVIEWER</p>	
<p>63. SIGNATURE OF INTERVIEWER</p>		<p>64. SIGNATURE OF INTERVIEWER</p>	
<p>65. SIGNATURE OF INTERVIEWER</p>		<p>66. SIGNATURE OF INTERVIEWER</p>	
<p>67. SIGNATURE OF INTERVIEWER</p>		<p>68. SIGNATURE OF INTERVIEWER</p>	
<p>69. SIGNATURE OF INTERVIEWER</p>		<p>70. SIGNATURE OF INTERVIEWER</p>	
<p>71. SIGNATURE OF INTERVIEWER</p>		<p>72. SIGNATURE OF INTERVIEWER</p>	
<p>73. SIGNATURE OF INTERVIEWER</p>		<p>74. SIGNATURE OF INTERVIEWER</p>	
<p>75. SIGNATURE OF INTERVIEWER</p>		<p>76. SIGNATURE OF INTERVIEWER</p>	
<p>77. SIGNATURE OF INTERVIEWER</p>		<p>78. SIGNATURE OF INTERVIEWER</p>	
<p>79. SIGNATURE OF INTERVIEWER</p>		<p>80. SIGNATURE OF INTERVIEWER</p>	
<p>81. SIGNATURE OF INTERVIEWER</p>		<p>82. SIGNATURE OF INTERVIEWER</p>	
<p>83. SIGNATURE OF INTERVIEWER</p>		<p>84. SIGNATURE OF INTERVIEWER</p>	
<p>85. SIGNATURE OF INTERVIEWER</p>		<p>86. SIGNATURE OF INTERVIEWER</p>	
<p>87. SIGNATURE OF INTERVIEWER</p>		<p>88. SIGNATURE OF INTERVIEWER</p>	
<p>89. SIGNATURE OF INTERVIEWER</p>		<p>90. SIGNATURE OF INTERVIEWER</p>	
<p>91. SIGNATURE OF INTERVIEWER</p>		<p>92. SIGNATURE OF INTERVIEWER</p>	
<p>93. SIGNATURE OF INTERVIEWER</p>		<p>94. SIGNATURE OF INTERVIEWER</p>	
<p>95. SIGNATURE OF INTERVIEWER</p>		<p>96. SIGNATURE OF INTERVIEWER</p>	
<p>97. SIGNATURE OF INTERVIEWER</p>		<p>98. SIGNATURE OF INTERVIEWER</p>	
<p>99. SIGNATURE OF INTERVIEWER</p>		<p>100. SIGNATURE OF INTERVIEWER</p>	

1000 Hollins St. Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02894

2902

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY BA LTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines		d. STREET ADDRESS 328 S. Augusta Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last JULIA AMANDA WALDSCHMIDT		4. DATE OF DEATH Month Day Year March 21, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alpheus Pulley		14. MOTHER'S MAIDEN NAME Sophia Siems	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 705-05-2979	
17. INFORMANT Mrs. Constance Berglund		Address 328 S. Augusta Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 33 IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 6 hours 15 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1953 , to MARCH 31, 1959 , that I last saw the deceased alive on MARCH 24, 1959 , and that death occurred at 2 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4808 FREDERICK AVE 3/22/59			
ACTUAL SIGNATURE H. Sander & Sons, Inc. M.D.		PHYSICIAN'S NAME (Type) H. Sander & Sons, Inc.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 23, 1959	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Sander & Sons, Inc.		24a. REC'D BY REGISTRAR MAR 24 '59	
ADDRESS Balto., Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2711 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02895
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7609 Gum Road			d. STREET ADDRESS 7609 Gum Road		
3. NAME OF DECEASED (Type or print) Anna (Lillie R. Waller			4. DATE OF DEATH Month Mar. Day 3, Year 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1886		9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Food Packer		10b. KIND OF BUSINESS OR INDUSTRY Langs Packg. Co.		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Whitmore			14. MOTHER'S MAIDEN NAME Anna ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-05-4856		17. INFORMANT Mr. Harry L. Waller Address 7609 Gum Road 22 Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 3 min
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Jack E Collins		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3-4-59	
EXAMINER'S NAME (Type) JACK E COLLINS		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 5, 59	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn		22d. LOCATION (City, town, or county) (State) Eastern Blvd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA		ADDRESS 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR MAR 6 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

3111
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH: _____ TIME OF DEATH: _____

PLACE OF DEATH: _____

DECEASED'S NAME: _____

AGE: _____ SEX: _____

RACE: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

EDUCATION: _____

OCCUPATION: _____

CAUSE OF DEATH: _____

MANNER OF DEATH: _____

DISPOSITION OF BODY: _____

SIGNATURE OF EXAMINER: _____

DATE: _____

PLACE: _____

STATE: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2903

CERTIFICATE OF DEATH

02896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall		c. LENGTH OF STAY IN TB Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9441 Belair Rd.		d. STREET ADDRESS 9441 Belair Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Selma M. Walter		4. DATE OF DEATH Month Day Year March 10, 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1897
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Herman Schwartz		14. MOTHER'S MAIDEN NAME Caroline Dietz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Lewis C. Walter		Address 9441 Belair Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CORONARY THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 8 HOURS 18 YRS.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE 2, 1948, to MAR. 10, 1959, that I last saw the deceased alive on MAR. 10, 1959, and that death occurred at 4:45 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Adam G. Swiss M.D. 6232 BELAIR ROAD PHYSICIAN'S NAME (Type) ADAM G. SWISS BALTIMORE 6, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 14, 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Michael's Lutheran		22d. LOCATION (City, town, or county) (State) Perry Hall, Balto. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine Funeral Home		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE MAR 12 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02897

2904

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 01X-2		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flintstone, Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		d. STREET ADDRESS Route # 2	
3. NAME OF DECEASED (Type or print) First Francis Middle L. Last Wandless		4. DATE OF DEATH Month 3 Day 13 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/23/42
9. AGE (In years last birthday) 16 yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred Wandless	
14. MOTHER'S MAIDEN NAME Annie Cole		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no	
16. SOCIAL SECURITY NO. -----		17. INFORMANT Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis and hydro-nephrosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 2:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter W. Rieckert		ADDRESS (Street, city or town, state) 4307 Mainfield Ave Baltimore	
PHYSICIAN'S NAME (Type) Peter W. Rieckert		DATE SIGNED 3-14-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-16-59	
22c. NAME OF CEMETERY OR CREMATORY ZION MEMORIAL		22d. LOCATION (City, town, or county) (State) ALLEGANY CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight, Cumberland-md		24a. REC'D BY REGISTRAR MAR 19 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Date of registration		12. Office of registration	
13. Name of funeral home		14. Name of cemetery		15. Name of burial place		16. Name of interment place	
17. Name of next of kin		18. Name of executor		19. Name of administrator		20. Name of guardian	
21. Name of trustee		22. Name of beneficiary		23. Name of heir		24. Name of legatee	
25. Name of devisee		26. Name of remainderman		27. Name of life tenant		28. Name of tenant in common	
29. Name of joint tenant		30. Name of tenant by the entirety		31. Name of tenant in fee simple		32. Name of tenant in fee simple	
33. Name of tenant in fee simple		34. Name of tenant in fee simple		35. Name of tenant in fee simple		36. Name of tenant in fee simple	
37. Name of tenant in fee simple		38. Name of tenant in fee simple		39. Name of tenant in fee simple		40. Name of tenant in fee simple	
41. Name of tenant in fee simple		42. Name of tenant in fee simple		43. Name of tenant in fee simple		44. Name of tenant in fee simple	
45. Name of tenant in fee simple		46. Name of tenant in fee simple		47. Name of tenant in fee simple		48. Name of tenant in fee simple	
49. Name of tenant in fee simple		50. Name of tenant in fee simple		51. Name of tenant in fee simple		52. Name of tenant in fee simple	
53. Name of tenant in fee simple		54. Name of tenant in fee simple		55. Name of tenant in fee simple		56. Name of tenant in fee simple	
57. Name of tenant in fee simple		58. Name of tenant in fee simple		59. Name of tenant in fee simple		60. Name of tenant in fee simple	
61. Name of tenant in fee simple		62. Name of tenant in fee simple		63. Name of tenant in fee simple		64. Name of tenant in fee simple	
65. Name of tenant in fee simple		66. Name of tenant in fee simple		67. Name of tenant in fee simple		68. Name of tenant in fee simple	
69. Name of tenant in fee simple		70. Name of tenant in fee simple		71. Name of tenant in fee simple		72. Name of tenant in fee simple	
73. Name of tenant in fee simple		74. Name of tenant in fee simple		75. Name of tenant in fee simple		76. Name of tenant in fee simple	
77. Name of tenant in fee simple		78. Name of tenant in fee simple		79. Name of tenant in fee simple		80. Name of tenant in fee simple	
81. Name of tenant in fee simple		82. Name of tenant in fee simple		83. Name of tenant in fee simple		84. Name of tenant in fee simple	
85. Name of tenant in fee simple		86. Name of tenant in fee simple		87. Name of tenant in fee simple		88. Name of tenant in fee simple	
89. Name of tenant in fee simple		90. Name of tenant in fee simple		91. Name of tenant in fee simple		92. Name of tenant in fee simple	
93. Name of tenant in fee simple		94. Name of tenant in fee simple		95. Name of tenant in fee simple		96. Name of tenant in fee simple	
97. Name of tenant in fee simple		98. Name of tenant in fee simple		99. Name of tenant in fee simple		100. Name of tenant in fee simple	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2905

CERTIFICATE OF DEATH

02898

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>10 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House - in - the Pines</u>				e. STREET ADDRESS <u>Washington Blvd</u>			
3. NAME OF DECEASED (Type or print) <u>Myra E. Waters</u>				4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 28, 1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George W. Waters II</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Cross</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs Carter Myers, Knoxville Tenn.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Generalized Arteriosclerosis</u> DUE TO <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>3da</u> <u>15 yrs. (?)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <u> </u> p. m. <u> </u>		Month, Day, Year <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>11-25-1942</u> , to <u>3-9-1959</u> , that I last saw the deceased alive on <u>3-8-1959</u> , and that death occurred at <u>6:30 P. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>				M.D. <u>Baltimore-26, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				<u>Baltimore-26, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 11, 1959</u>		<u>Long Hill Cem.</u>		<u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Donaldson</u>				ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 13 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02899

2906

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Zwaker Bottom Rd #1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Georgie</u> Middle <u>Emma</u> Last <u>Watkins</u>				4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2 August 1872</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Monkton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Bryan</u>				14. MOTHER'S MAIDEN NAME <u>Jane Howard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>219-384963</u>		17. INFORMANT Address <u>Ella Doney - daughter - Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerotic cardiovascular disease</u> DUE TO (c) <u>over 10 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>August</u> , 19 <u>49</u> , to <u>March</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12 March</u> , 19 <u>59</u> , and that death occurred at <u>5:45 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Walter T. Kees</u>				DATE SIGNED <u>Coebeysville, Md 12 March 1959</u>			
ACTUAL SIGNATURE <u>Walter T. Kees</u>				M.D. <u>Walter T. Kees</u>			
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-16-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. LUKE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HEREFORD, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Jackson Inc.</u>				ADDRESS <u>916 PENNA. AVE.</u>		24a. REC'D BY REGISTRAR <u>MAR 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>			

2907

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TANEY TOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS Route # 2	
3. NAME OF DECEASED (Type or print) First HOLLAND Middle FRANKLIN Last WEANT		4. DATE OF DEATH Month 3 Day 31 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/8/1899
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HAMWICK		14. MOTHER'S MAIDEN NAME LOUISE FARRER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 199-03-063	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE BRONCHUS 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/13 , 19 59 , to 3/31 , 19 59 , that I last saw the deceased alive on 3/31 , 19 59 , and that death occurred at 3:15 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED			
ACTUAL SIGNATURE W. Newcomer		M.D. Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr 3 1959	22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery	22d. LOCATION (City, town, or county) (State) Harney Carroll Co. Md
23. FUNERAL DIRECTOR'S SIGNATURE CD Fessenden		24a. REC'D BY REGISTRAR DATE APR 2 '59	
ADDRESS Taneytown Md		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - BUREAU OF VETERINARY MEDICINE

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverton</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		d. STREET ADDRESS <u>11608 Riverton Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frank Louis Webb</u>		4. DATE OF DEATH Month Day Year <u>March 7 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4 1881</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Advertising Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Advertising Business</u>	
11. BIRTH PLACE (State or foreign country) <u>Steubenville, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Webb</u>		14. MOTHER'S MAIDEN NAME <u>Maey Davis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war and dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Mr. Bumpke Jr. 9811 4607 Roland - 10</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion.</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>sudden</u> <u>1953</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-26</u> , 19 <u>57</u> , to <u>3-7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-23</u> , 19 <u>59</u> , and that death occurred at <u>10³⁰</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred A. Ossman</u> M.D.		ADDRESS (Street, city or town, state) <u>1101 St Paul St Balto MD</u>	
PHYSICIAN'S NAME (Type) <u>Alfred A. Ossman</u>		DATE SIGNED <u>3-9-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Mar 10 1959</u>	<u>Green Mount</u>	<u>Balto - 3 - MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Morris</u>		ADDRESS <u>108 W York - 2</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2903
CERTIFICATE OF DEATH

02902

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1310 Ridge Road</u>				d. STREET ADDRESS <u>11310 Ridge Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna C. Wharton</u> First Middle Last				4. DATE OF DEATH <u>March 24</u> 19 <u>59</u> Month Day Year			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/17/1883</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Clark</u>				14. MOTHER'S MAIDEN NAME <u>Chapman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		INFORMANT <u>James H. Wharton</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Arteriosclerotic cerebral cardiovascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs +</u>			
DUE TO (b) <u>Diabetes Mellitus</u>				5 yrs +			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cellulitis + beginning gangrene - Rt. foot.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February</u> , 19 <u>59</u> , to <u>24 March</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>24 March</u> , 19 <u>59</u> , and that death occurred at <u>11:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John A. Nesbitt, Jr.</u>				ADDRESS (Street, city or town, state) <u>1118 St Paul St. Baltimore 23 Md</u>		DATE SIGNED <u>3-25-59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nabt + Son</u>				ADDRESS <u>28</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 30 59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12505

STATE OF CALIFORNIA

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

2910

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Idlewylde (Balto. 12)			c. LENGTH OF STAY IN 1b Idlewylde (Balto. 12)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1906 Limit Avenue			d. STREET ADDRESS 1306 Limit Avenue		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) IRVIN W. WILLIAMS			4. DATE OF DEATH Month March Day 20 Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1882		9. AGE (In years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer—retired		10b. KIND OF BUSINESS OR INDUSTRY City Water Dept.		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. None		17. INFORMANT Irvin F. Williams Address 1306 Limit Ave., Balto. 12, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH 5 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles F. O'Donovan		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/20/59	
EXAMINER'S NAME (Type) Charles F. O'Donovan		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 25, 1959		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
				22d. LOCATION (City, town, or county) (State) Elkridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland			ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR DATE MAR 26 '59
			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2010

Dec 1, 1910

John J. Jones

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Dec 1, 1910

John J. Jones

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John J. Jones

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John J. Jones

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John J. Jones

John J. Jones

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2911

CERTIFICATE OF DEATH

04101

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 3701-4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 12 yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 S. Fremont Avenue - Baltimore		d. STREET ADDRESS 42 South Fremont Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louise Middle Williams Last Williams		4. DATE OF DEATH Month March Day 29 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-28-1902
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR: Months 56 Days 56 Hours 56 Min. 56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stenographer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Faust		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1955 , to March 29, 1959 , that I last saw the deceased alive on March 29, 1959 , and that death occurred at 9:15 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 3-30-59			
ACTUAL SIGNATURE Stella Wachsler		M.D. SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4-15-59	
22c. NAME OF CEMETERY OR CREMATORY U. S. Ind. Med. School		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a. REC'D BY REGISTRAR APR 21 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12 FilmG240 4-3-59 at

02905

CERTIFICATE OF DEATH

2912

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		STATE <u>MD.</u> COUNTY <u>✓</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>		COUNTY <u>3 Vol-4</u>	
CITY OR TOWN <u>FULLERTON</u>		LENGTH OF STAY (in this place) <u>2 1/2 MONTHS</u>		STREET ADDRESS <u>3907 HUDSON ST.</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>FULLERTON NURSING HOME</u>							
3. NAME OF DECEASED (Type or Print) <u>ANDREW</u> (First) <u>WILLNER</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>Mar.</u> (Day) <u>27</u> (Year) <u>19 59</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>4/28/1868</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STANDARD OIL CO.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GERMANY</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN WILLNER</u>				14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Wm. ROWE, 523 St. FRANCIS RD (4) TOWSON, MD.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153.3 IMMEDIATE CAUSE (A) <u>Carcinoma Sigmoid</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Dec. 29 1958</u>		19b. MAJOR FINDINGS OF OPERATION <u>See Sigmoid - inoperable - (biopsy done)</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec.</u> , 19 <u>58</u> , to <u>Mar. 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Mar. 18</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Dough Tomney</u>		M.D. <u>4414 Killewood Dr. Balt. Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>3/28/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/31/59</u>		NAME OF CEMETERY <u>OAK LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO. Co. MD.</u>	
24. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>C.F. Hoffmann</u>		ADDRESS <u>3218 HUDSON ST.</u>	
DATE <u>MAR 30 '59</u>							

CERTIFICATE OF DEATH

REG. NO. 12345

1. NAME OF DECEASED JOHN J. VEK		2. PLACE OF BIRTH BALTIMORE, MARYLAND	
3. DATE OF BIRTH JAN 15 1901		4. SEX MALE	
5. OCCUPATION LABORER		6. CAUSE OF DEATH HEART DISEASE	
7. DATE OF DEATH JAN 15 1951		8. PLACE OF DEATH HOME	
9. SIGNATURE OF DECEASED JOHN J. VEK		10. SIGNATURE OF WITNESS JOHN J. VEK	
11. SIGNATURE OF PHYSICIAN JOHN J. VEK		12. SIGNATURE OF CLERK JOHN J. VEK	
13. SIGNATURE OF REGISTRAR JOHN J. VEK		14. SIGNATURE OF DECEASED JOHN J. VEK	
15. SIGNATURE OF WITNESS JOHN J. VEK		16. SIGNATURE OF PHYSICIAN JOHN J. VEK	
17. SIGNATURE OF CLERK JOHN J. VEK		18. SIGNATURE OF REGISTRAR JOHN J. VEK	
19. SIGNATURE OF DECEASED JOHN J. VEK		20. SIGNATURE OF WITNESS JOHN J. VEK	
21. SIGNATURE OF PHYSICIAN JOHN J. VEK		22. SIGNATURE OF CLERK JOHN J. VEK	
23. SIGNATURE OF REGISTRAR JOHN J. VEK		24. SIGNATURE OF DECEASED JOHN J. VEK	
25. SIGNATURE OF WITNESS JOHN J. VEK		26. SIGNATURE OF PHYSICIAN JOHN J. VEK	
27. SIGNATURE OF CLERK JOHN J. VEK		28. SIGNATURE OF REGISTRAR JOHN J. VEK	
29. SIGNATURE OF DECEASED JOHN J. VEK		30. SIGNATURE OF WITNESS JOHN J. VEK	
31. SIGNATURE OF PHYSICIAN JOHN J. VEK		32. SIGNATURE OF CLERK JOHN J. VEK	
33. SIGNATURE OF REGISTRAR JOHN J. VEK		34. SIGNATURE OF DECEASED JOHN J. VEK	
35. SIGNATURE OF WITNESS JOHN J. VEK		36. SIGNATURE OF PHYSICIAN JOHN J. VEK	
37. SIGNATURE OF CLERK JOHN J. VEK		38. SIGNATURE OF REGISTRAR JOHN J. VEK	
39. SIGNATURE OF DECEASED JOHN J. VEK		40. SIGNATURE OF WITNESS JOHN J. VEK	
41. SIGNATURE OF PHYSICIAN JOHN J. VEK		42. SIGNATURE OF CLERK JOHN J. VEK	
43. SIGNATURE OF REGISTRAR JOHN J. VEK		44. SIGNATURE OF DECEASED JOHN J. VEK	
45. SIGNATURE OF WITNESS JOHN J. VEK		46. SIGNATURE OF PHYSICIAN JOHN J. VEK	
47. SIGNATURE OF CLERK JOHN J. VEK		48. SIGNATURE OF REGISTRAR JOHN J. VEK	
49. SIGNATURE OF DECEASED JOHN J. VEK		50. SIGNATURE OF WITNESS JOHN J. VEK	
51. SIGNATURE OF PHYSICIAN JOHN J. VEK		52. SIGNATURE OF CLERK JOHN J. VEK	
53. SIGNATURE OF REGISTRAR JOHN J. VEK		54. SIGNATURE OF DECEASED JOHN J. VEK	
55. SIGNATURE OF WITNESS JOHN J. VEK		56. SIGNATURE OF PHYSICIAN JOHN J. VEK	
57. SIGNATURE OF CLERK JOHN J. VEK		58. SIGNATURE OF REGISTRAR JOHN J. VEK	
59. SIGNATURE OF DECEASED JOHN J. VEK		60. SIGNATURE OF WITNESS JOHN J. VEK	
61. SIGNATURE OF PHYSICIAN JOHN J. VEK		62. SIGNATURE OF CLERK JOHN J. VEK	
63. SIGNATURE OF REGISTRAR JOHN J. VEK		64. SIGNATURE OF DECEASED JOHN J. VEK	
65. SIGNATURE OF WITNESS JOHN J. VEK		66. SIGNATURE OF PHYSICIAN JOHN J. VEK	
67. SIGNATURE OF CLERK JOHN J. VEK		68. SIGNATURE OF REGISTRAR JOHN J. VEK	
69. SIGNATURE OF DECEASED JOHN J. VEK		70. SIGNATURE OF WITNESS JOHN J. VEK	
71. SIGNATURE OF PHYSICIAN JOHN J. VEK		72. SIGNATURE OF CLERK JOHN J. VEK	
73. SIGNATURE OF REGISTRAR JOHN J. VEK		74. SIGNATURE OF DECEASED JOHN J. VEK	
75. SIGNATURE OF WITNESS JOHN J. VEK		76. SIGNATURE OF PHYSICIAN JOHN J. VEK	
77. SIGNATURE OF CLERK JOHN J. VEK		78. SIGNATURE OF REGISTRAR JOHN J. VEK	
79. SIGNATURE OF DECEASED JOHN J. VEK		80. SIGNATURE OF WITNESS JOHN J. VEK	
81. SIGNATURE OF PHYSICIAN JOHN J. VEK		82. SIGNATURE OF CLERK JOHN J. VEK	
83. SIGNATURE OF REGISTRAR JOHN J. VEK		84. SIGNATURE OF DECEASED JOHN J. VEK	
85. SIGNATURE OF WITNESS JOHN J. VEK		86. SIGNATURE OF PHYSICIAN JOHN J. VEK	
87. SIGNATURE OF CLERK JOHN J. VEK		88. SIGNATURE OF REGISTRAR JOHN J. VEK	
89. SIGNATURE OF DECEASED JOHN J. VEK		90. SIGNATURE OF WITNESS JOHN J. VEK	
91. SIGNATURE OF PHYSICIAN JOHN J. VEK		92. SIGNATURE OF CLERK JOHN J. VEK	
93. SIGNATURE OF REGISTRAR JOHN J. VEK		94. SIGNATURE OF DECEASED JOHN J. VEK	
95. SIGNATURE OF WITNESS JOHN J. VEK		96. SIGNATURE OF PHYSICIAN JOHN J. VEK	
97. SIGNATURE OF CLERK JOHN J. VEK		98. SIGNATURE OF REGISTRAR JOHN J. VEK	
99. SIGNATURE OF DECEASED JOHN J. VEK		100. SIGNATURE OF WITNESS JOHN J. VEK	



EXPLANATIONS

TO OBTAIN A CERTIFICATE OF DEATH, THE DECEASED MUST BE A RESIDENT OF MARYLAND AT THE TIME OF DEATH. THE CERTIFICATE OF DEATH IS A LEGAL DOCUMENT AND MUST BE FILED WITH THE DEPARTMENT OF HEALTH. THE DEPARTMENT OF HEALTH IS RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION ON THE CERTIFICATE OF DEATH. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION ON THE CERTIFICATE OF DEATH. THE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION ON THE CERTIFICATE OF DEATH.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02906

2913

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7101 Campfield Road</u>				d. STREET ADDRESS <u>5310 Catalpha Road</u>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Marie B. Wilson</u>				4. DATE OF DEATH <u>March 13, 1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 6, 1881</u>	9. AGE (In years lost birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Malone</u>			14. MOTHER'S MAIDEN NAME <u>Mary Craig</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. William Mader, 7101 Campfield Road.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MARCH 12, 1959</u> , to <u>MARCH 13, 1959</u> , that I last saw the deceased alive on <u>MARCH 12, 1959</u> , and that death occurred at <u>10:05 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel D. Scalia</u> M.D.				ADDRESS (Street, city or town, state) <u>1331 REISTERSTOWN ROAD</u> DATE SIGNED <u>3-13-59</u>			
PHYSICIAN'S NAME (Type) <u>PIKESVILLE 8 MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR <u>MAR 16 '59</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2914

CERTIFICATE OF DEATH

02907

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <i>16 Jussieu Avenue House in Pines Nursing Home</i>				d. STREET ADDRESS <i>609 N. Highland Avenue</i>			
3. NAME OF DECEASED (Type or print) <i>Edgar M. Wolf, Sr.</i>				4. DATE OF DEATH Month <i>3</i> Day <i>5</i> Year <i>1959</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 9, 1880</i>	9. AGE (In years last birthday) <i>78</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Wolf</i>				14. MOTHER'S MAIDEN NAME <i>Annie Crouse</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mrs. Mabel Evans, 1509 Cranwell Rd.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Atherosclerosis</i> (c) <i>Generalized atherosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>10 yrs. (3)</i> <i>10 yrs. (3)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-21-1958</i> , to <i>3-5-1959</i> , that I last saw the deceased alive on <i>3-4-1959</i> , and that death occurred at <i>1:30 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Wilmer K. Gallager</i>				ADDRESS (Street, city or town, state) <i>6209 Frederick Rd.</i>		DATE SIGNED <i>3-5-59</i>	
PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallager</i>				<i>Baltimore-28, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/9/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>L.J. Ruck, Inc. 5305 Harford Rd. #14</i>				24a. REC'D BY REGISTRAR DATE <i>MAR 9 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

